City of Atlanta

Retiree Employee Benefits Program
September 2009 – August 2010

RETIREE SELF SERVICE
YOU CAN NOW ENROLL ONLINE

Health Plans * Dental Plans
Life and Vision Plan * Contracted Vendors
Rate Structure * Dependent Eligibility Chart

OPEN ENROLLMENT CAN NOW BE DONE ONLINE!

OPEN ENROLLMENT OVERVIEW

*This year's Open Enrollment Period is **July 6th – July 22nd** for all active and retired City of Atlanta employees. We consider this Open Enrollment as a passive enrollment period, which means that no significant changes were made to the Medical, Dental and Vision Plans. However, the Life Insurance carrier has changed. The new life provider is Greater Georgia Life. Please see the enrollment guide for plan details.*

*The option that you select will be effective September 1, 2009 and remain in effect until August 31, 2010 unless you have a qualifying life event. If you **do not** wish to make changes for the new benefit plan year, you are not required to return an application. However, if you need to continue coverage for dependents (19-26) that are Full-Time Students, please use the Life Event Change Form and attach documentation. If you would like to make changes to your benefit selections, please submit the enclosed application with the appropriate documentation. All Open Enrollment Applications with benefit changes are due to Department of Human Resources (DHR) - Insurance Division no later than July 22, 2009. If you are completing the application online, Open Enrollment will close at 11:59 p.m. July 22, 2009.*

THIS BOOK IS NOT A CONTRACT

This book provides a summary of benefits available to City of Atlanta retirees, and their eligible dependents, as well as the procedures to be followed to obtain these benefits. However, if inconsistencies occur between the contents of this book and the contracts, rules or laws regulating administration of the various plans, please understand that the terms set forth in each plan must be followed. In some instances, limitations and exclusions may apply. The DHR – Insurance Division has made great efforts to provide accurate and up-to-date information to the best of our ability for City of Atlanta retirees and their dependents within this document. However, this booklet excludes any warranty, whether expressed or implied, on the admissions and/or errors which may be found therein; nor does the City take any responsibility whatsoever for third party information.

Should you have questions or if you are uncertain about your benefits, call the plan representative or the DHR – Insurance Division at (404) 330-6036 for assistance.

PLEASE NOTE: Unmarried children who are full-time students, between the ages of 19 and 26 are insurable, even if they were not insured prior to age 19. When first insuring them you must provide a birth certificate showing a parent-child relationship with the employee/retiree and or spouse, plus a statement from the school registrar's office or verification from www.studentclearinghouse.org (small fee may apply) showing full-time student status. Full-time student status **MUST** be confirmed at a minimum annually.

A dependent child who returns to full-time student status during the contract year is eligible to be covered provided the **Full-time Student Statement** and **Change Form** are submitted **within 31 days** of the start of full-time status.

In order to obtain or continue coverage in a City of Atlanta plan, a **retiree** must enroll in Medicare Parts A and B, upon becoming eligible to do so. At the time your coverage in parts A and B begins, you must change your enrollment to a Medicare Advantage Plan.

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****See back (insert) for application and instructions.***

COVERAGE CHANGES
09/01/2009 - 08/31/2010

Kaiser Permanente HMO	**No changes**
Kaiser Permanente Senior Advantage	**No changes**
Blue Cross/Blue Shield POS	**No changes**
Blue Cross/Blue Shield of Georgia	**SmartValue Medicare Fee for Service Managed Plan for retirees and/or spouses who are covered by both Parts A and B of Medicare. Higher pharmacy and catastrophic coverage limits/copays; lower hospital per admission copay; lower Skilled Nursing facility copay; lower DME (Durable Medical Equipment) copay; higher annual out-of-pocket maximum.**
Greater Georgia Life	**Newborns (birth - 6 months) - $600.00**
OptumHealth Vision *(previously Spectera Vision)*	**Rate reduction**
CIGNA Dental	**Adult orthodontia**
Humana (CompBenefits) Dental/DHMO	**No changes**

Note Major Changes for Medicare Eligible Retirees.

All Medicare eligible retirees and/or spouses must enroll in both Parts A and B and are then eligible for BCBS SmartValue or Kaiser Permanente Senior Advantage.

If you and/or your spouse are eligible for Medicare, and not currently enrolled in parts A and B, to continue coverage in a City of Atlanta Plan, you must enroll in Parts A and B when eligible (at age 65, within 8 months of retirement, or at the next Medicare General Enrollment Period, 01/01/2010 - 03/31/2010). At the time your coverage in parts A and B begins, you must change your enrollment to a Medicare Advantage Plan.

Helpful Contact Information:

Social Security:	**1-800-772-1213** **www.socialsecurity.gov**
Medicare:	**1-800-633-4227** **www.medicare.gov**

Please check the blue pages in your telephone book for the Social Security office nearest to your residence.

Open Enrollment Period — July 6, 2009 - July 22, 2009

BENEFITS HIGHLIGHTS

PROVIDERS	OPTIONS
HEALTH INSURANCE	***OPTIONS (4)***
Blue Cross/Blue Shield of Georgia **(800) 368-0766** www.bcbsga.com	POS
SmartValue PFFS **(877) 326-2201**	Medicare Advantage
Kaiser Permanente **(404) 261-2590** or **(888) 865-5813** www.kp.org	HMO Senior Advantage
DENTAL INSURANCE	***OPTIONS (4)***
CIGNA **(800) CIGNA24** or **(800) 244-6224** www.mycigna.com	High Option Low Option
Humana (CompBenefits) **(800) 342-5209** www.compbenefits.com	Dental Access Dental DHMO
VISION	
OptumHealth Vision **(800) 638-3120** *(formerly Spectera Vision)* www.myoptumhealth.com	
LIFE INSURANCE	
Greater Georgia Life Insurance Company Administration **(800) 851-8544** Claims **(800) 552-2137** www.bcbsga.com	Retiree Life Insurance Plan Dependent Life Insurance Plan Surviving Spouse Life Insurance Plan

Your current coverage continues through August 31, 2009.

Open Enrollment Period is July 6, 2009 – July 22, 2009.

Coverage Plan Year is September 1, 2009 – August 31, 2010.

HOW TO USE YOUR BENEFITS BOOKLET

Getting the Most From Your Benefits

Revolutionary changes are taking place in the design and implementation of health insurance. This year, the City is offering one Health Maintenance Organization (HMO), one Point of Service (POS) and one Medicare Managed Care plan. Because of constant changes and the rising cost of health care, retirees need more information regarding health and life insurance benefits in order to deal with the variety of choices you are asked to make. However, becoming knowledgeable and making the most effective decisions regarding your benefits is not easy. But insurance is important, so the effort is definitely worthwhile. This booklet provides the information necessary to answer the benefits questions by offering a clear picture of all benefits provided by the City of Atlanta for you – the retiree. One of the first necessary steps to take is to learn which insurance plans your physician will accept in 2009-2010 and the provisions of your particular carrier. Once you understand your coverage, you will gain the confidence to take control of your benefits.

How to Use This Booklet

This book presents basic information about a wide range of options. It is written as a starting point to lay out possibilities for your consideration. You will need to explore in detail the plans of greatest interest to be sure that you have relevant, up-to-date facts before making a decision. As you go through your benefits booklet, you will find guidelines designed to help you analyze your benefits. If you cannot find the answers in this booklet, call your carrier and request additional information. You should try to attend an Open Enrollment Meeting even if you already have coverage with which you are satisfied, you may desire a better understanding of that coverage. This booklet will instruct you on how to protect yourself and your family in the event your needs change. It identifies guidelines to use in comparing plans when you are selecting insurance. The benefits booklet also explains how to adjust your coverage to reflect major life changes such as a new baby, marriage, divorce, children going to college, leaving the City, retirement, and/or the death of a loved one.

Each section of this booklet should be considered separately, as there is no automatic connection. Your health and dental insurance providers may be different.Your life insurance carrier will also be different. Therefore, it is necessary to approach this book one section at a time.

Health Terms

The list of terms in the *Glossary* section, located in the back of this book, may be helpful. Various health care terms and options are defined and explained, such as “deductibles,” “coinsurance,” “UCR,” and more. This will help you become familiar with some of the language of the benefits industry and health insurance providers.

Select Carefully

The information in this booklet offers you the information you must have to be an effective manager of your benefits. After all, who cares more about conserving your resources than you? Choices available are for the financial protection of retirees and their dependents. Please review your booklet carefully before making your final selection. Remember, only you – the retiree – are capable of making the most beneficial decision for you.

You DO NOT have to return an application during Open Enrollment UNLESS:

- ***You do not have coverage, and want insurance in the plan year 09/01/2009 - 08/31/2010.***
- ***You want to change carriers.***
- ***You want to add or delete a dependent.***
- ***You are submitting the required full-time student documentation for a dependent child between the ages of 19 - 26. (Failure to submit full-time student documentation will terminate the dependent’s coverage 08/31/2009). Please return the form in the Open Enrollment package along with the full-time student documentation. If you are not making any other changes then there is no need to return a completed application. Full-time student documentation can also be obtained on line at www.studentclearinghouse.org (a small fee may apply).***
- ***You and/or your spouse are Medicare eligible and need to sign up for a Medicare Advantage Plan (Kaiser Senior Advantage or BCBS SmartValue).***

HOW TO USE YOUR BENEFITS BOOKLET *(cont'd)*

SPECIAL NOTE TO RETIREES

If you and/or your spouse are covered by both Medicare Parts A and B, you must attach a copy of your and/or your spouse's Medicare card to the Open Enrollment Application and enroll in either Kaiser Senior Advantage or Blue Cross/Blue Shield SmartValue.

If you live in the state of Georgia, the following selections are available for the plan year 09/01/2009 - 08/31/2010:

Kaiser Permanente will continue to offer SENIOR ADVANTAGE to retirees who have both parts A and B of Medicare and live within their Senior Advantage Service Area, which includes the same counties as the Kaiser HMO Plan.

Blue Cross/Blue Shield will offer SmartValue, a Medicare Advantage Private Fee For Service Plan (PFFS), to retirees and/or spouses who have both parts A and B of Medicare. The national network will include all providers accepting Medicare and willing to accept BCBS SmartValue reimbursements and rules.

PLEASE NOTE: To participate in the a Medicare Advantage Plan, you will have to complete a separate application which will be mailed to your home by the insurance carrier. If in a future year you want to change from a Medicare Advantage Plan to another plan, there is a separate termination form, available from the carrier, to complete.

PLEASE NOTE:

If you are Medicare eligible, you **must** enroll in Parts A and B to be covered under any City of Atlanta Plan. If you are not Medicare eligible, you may continue with the City's non Medicare Plans.

If you sign up for any **Medicare Advantage Plan** (other than Senior Advantage offered by Kaiser or Blue Cross Blue Shield SmartValue) that may be offered to you directly by various vendors, including just Medicare Part D for prescription drugs, **YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED**. If you have any questions about this, please call the DHR – Insurance Division at **(404) 330-6036** before signing up for another medical plan of any type.

BENEFITS OVERVIEW

In 2009-2010, the City of Atlanta will offer retirees a competitive flexible benefits program, consisting of the following:

Health Insurance

•

Dental Insurance

•

Life Insurance

•

Vision

These benefits are provided to City of Atlanta retirees (and their eligible dependents) through payroll deduction. Information concerning the above has been incorporated into this booklet, which provides important highlights about your insurance benefits. However, it is important to note that you may obtain more detailed, specific information on coverage by directly contacting the participating carrier. Each provider has representatives who are available to assist you with questions you may have concerning their coverage and your benefits.

Benefits Eligibility

Retirees, their surviving beneficiaries and their dependents are eligible to enroll in the City of Atlanta's health and dental plans. Of course, dependents must meet certain eligibility criteria to be considered. The following is a list of eligible dependents:

- A spouse (a husband or wife who is joined in marriage to a retiree by a ceremony recognized by the laws of the State of Georgia)
- A domestic partner (registered with the City of Atlanta)
- An unmarried dependent child of a retiree (until the end of the benefit year – August 31 – in which the child becomes 19)
- An unmarried child (19 through 26 years of age) who is attending an accredited educational institution on a **full-time basis**. Coverage ends at the end of the month the child reaches the limiting age. Coverage ends at the end of the month the unmarried child is no longer a student or at the end of the month the child reaches age 26.
- A legally adopted (unmarried) child under age 19 or a child for whom you have guardianship **(permanent or deemed permanent for insurance purposes)**
- A step-child (unmarried) under age 19 permanently residing with the retiree and supported by the retiree
- A child (unmarried) under age 19 and receiving court-ordered support
- A child (unmarried) 19 years or older who is incapable of self-support due to mental or physical disability, and who
  - Has a permanent disability
  - Resides permanently with and is supported by retiree
- A child, after attaining age 19, who is receiving a Pension Check as a Surviving Beneficiary and is covered by the City of Atlanta Group Plan must provide Full-Time Student Documentation. When eligibility for Pension ends due to age or change in School Enrollment Status, contact the DHR Insurance Division at **(404) 330-6036** to continue coverage.

DEPENDENT ELIGIBILITY DOCUMENTATION REQUIREMENTS

*Copies of the appropriate documents must be attached to your Open Enrollment Application.**
Note: All documentation should contain both your name and Social Security number.

DEPENDENTS	DOCUMENTATION REQUIRED
For Spouse	• Copy of Marriage Certificate. If previously married, death certificate or divorce decree.
For Removal of Spouse/Child	• None at Open Enrollment. Court Decree **within 31 days** of Decree during the contract year.
For Natural Child(ren)	• Child's Birth Certificate (showing a parent-child relationship to retiree and/or spouse)
For Adopted Child(ren)	• Placement Papers signed by the Courts.
For Overage Dependent (19-26 yrs of age)	• Statement from registrar of full-time student status from an accredited educational institution or online from www.studentclearinghouse.org at Open Enrollment or **within 31 days** of full-time student status (coverage terminates at the end of month of 26th birthday or graduation).
For Disabled Child (19 yrs and older)	• Physician Verification of permanent disability.
Foreign Adoptions	• Adoption Papers signed by the Courts • Visa showing date of entry to USA.
For Step Child(ren)	• Child's Birth Certificate (showing parent-child relationship with retiree's spouse). • Copy of Marriage Certificate.
For Court-Ordered Support	• State Affidavit. • Copy of signed Court Order requiring retiree to provide support for health coverage.
For Guardianship	• Court ordered guardianship deemed permanent for insurance purposes.
For Domestic Partner	• City of Atlanta Affidavit of Financial Reliance (Notarized) **within 31 days** of approval.
For Termination of Domestic Partner	• None at Open Enrollment. City of Atlanta Notice of Termination **within 31 days** of termination during the contract year.

Social Security number and date of birth must be provided for all dependents. Failure to submit the dependent's Social Security number will result in termination/denial of coverage (exceptions: newborns age 6 months or less).

Child(ren) must be unmarried.
Documentation also applies to life insurance coverage.
Documentation is not required at Open Enrollment to delete a dependent.

**In most cases, documentation is needed if the retiree is adding a dependent, making changes on a dependent's status, or for confirmation of student status.*

If both you and your spouse are insured under a City of Atlanta health/dental plan as an employee or retiree, your children may be insured as dependents of either you or your spouse, for health/dental coverage.

No city employee/retiree may be the dependent of another employee/retiree for health, vision or dental insurance. *However, for Life Insurance, a retiree may cover his/her spouse even if the spouse is an employee/retiree. Children may be insured by both parents for life insurance coverage.*

Documentation for full-time students must be submitted <u>within 31 days</u> of the beginning of the school term or returned with your Open Enrollment Application. Please keep a copy of any documentation that you send with your Enrollment Application.

All documentation should contain the retiree's name and Social Security number.

Confirmation audits of full-time student status may occur periodically during the coverage year. If full-time student status is not confirmed, coverage may be discontinued.

OPEN ENROLLMENT MEETINGS
PLAN YEAR 09/01/2009 - 08/31/2010

CITY OF ATLANTA
FY-2010 OPEN ENROLLMENT MEETING SCHEDULE
For the Benefit Year beginning September 1, 2009 and ending August 31, 2010

ASSISTANCE FOR SELF SERVE IS AVAILABLE 8:00 AM - 6:00 PM MONDAY 7/06/09 THROUGH THURSDAY 7/22/09

These meetings are the best time to get clarification concerning your benefits. The DHR Insurance Division staff will be available at all meetings and representatives from the carriers will be at most meetings.

WEEK DAY PRESENTATIONS

Thursday, July 9
Civic Center

Monday, July 13
City Hall East Presentation Room

Tuesday, July 14
City Hall Council Chambers

Wednesday, July 15
Civic Center

Presentation from 11:00 a.m. – 3:00 p.m.
Staff Available 10:30 a.m. - 3:00 p.m.

SATURDAY PRESENTATION

Saturday, July 18
Civic Center

Presentation from 11:00 am – 3:00 p.m.
Staff Available 10:30 p.m. - 3:00 p.m.

ENROLLMENT ASSISTANCE FOR SELF SERVE

Monday, July 6
through
Thursday, July 22
City Hall Tower Auditorium

No Formal Presentation
Enrollment Information and Assistance Available

Staff Available 8:00 a.m. - 6:00 p.m.

OPEN ENROLLMENT MEETING LOCATIONS

- ***Atlanta Civic Center***
  395 Piedmont Avenue, N.E. - Piedmont Room*
- ***City Hall Tower Auditorium***
  68 Mitchell St. - 3rd Floor (Old Council Chambers)
- ***City Hall Council Chambers***
  55 Trinity Ave., 2nd Floor
- ***City Hall East Presentation Room***
  675 Ponce de Leon, 1st Floor*
- ***Hartsfield-Jackson Development Program Technical Center***
  1255 South Loop Rd.*
- ***Hartsfield-Jackson Airport Gateway Conference Room***
  4th Floor Atrium - 6000 N. Terminal Parkway

**Free parking available.*

AIRPORT PRESENTATIONS

Friday, July 17
Airport Gateway Conference Room

Presentation at 8:30 a.m.
Staff Available 8:00 a.m. - 11:00 a.m.

Friday, July 17
Airport Technical Center

Presentation at 2:30 p.m.
Staff Available 2:00 p.m. - 4:00 p.m.

Applications for any Employee/Retiree making changes to their insurance coverage are to be entered online or, are due back to DHR – Insurance Division *no later than Wednesday, July 22, 2009*. Please read the Open Enrollment materials carefully to determine if you need to submit an application.

OPEN ENROLLMENT INSTRUCTIONS
09/01/2009 - 08/31/2010

Things you may find handy before logging in to "SSHR". Know the Primary Care Physicans name and 10 digit number plus the SSN of new dependents.

ENROLLING INTO YOUR COA BENEFITS USING ORACLE SELF SERVICE

Benefits Open Enrollment can now be done online! There are six main parts to this process and each is outlined in this step by step guide.

1. Access the Oracle www.atlantaga.gov
2. Click on Departments - Human Resources
3. Click on Employee/Retiree Benefits Home Page

Page 1: Dependents and Beneficiaries

This is where you will enter anyone you want to list as a dependent and or beneficiaries if they are not there.

4. Click Add Another Person .
5. Enter the person's **Name and Relationship**.
6. Enter their Address Information, or if they share the same residence as you, check the shared residence box.
7. Enter the Required Information: Student Status should only be entered for children 19 yrs. or older who are currently full-time students.
8. When finished, click Apply .
9. Repeat steps 5-9 as many times as necessary to enter Dependents and beneficiaries.
10. When you are Ready to Continue, click Next .

Page 2: Benefits Enrollments

This page will show an overview of available benefits and your current status. To enroll move to step 11.

11. Click Update Benefits
12. Check the boxes next to the benefits you want to select. You can Add Dependents and Beneficiaries at any time by clicking the button, although you will have to repeat the step you are on once you have added the additional people.
13. When you have made your selections and are Ready to continue, click Next .

Page 3: Update Benefits – Cover Dependents

This is where you will choose which dependents will be covered for your selected benefits.

14. Click on the box next to their name if you want them to be covered under this corresponding benefit.
15. When you have made your selections and are Ready to Continue, click Next .

Page 4: Update Beneficiaries : Add Beneficiaries

This is where you can specify what percentage of any Insurance payouts you want each of your beneficiaries to receive.

16. Choose which beneficiaries would receive anything as a primary recipient (for example, will your spouse receive 100% of the benefit if something happens to you).
17. Choose which beneficiaries would receive anything as a contingent recipient (for example, what will your children receive if something happens to you or your primary recipient)?
18. To recalculate your total, click Recalculate . Both the primary and contingent percentages should equal 100%.
19. Repeat for additional policies listed.
20. When you are ready to continue, click Next .

Page 5: Add Primary Care Providers

21. Depending on the plans you have selected for your medical and dental insurance, you may be asked to enter your primary care provider's ID, name and specialty.
22. When you are ready to continue, click Next .

Page 6: Confirmation Page

This page allows you to review everything you have selected.

- If you want a printable version of this page, click, Printable Page .
- If you want a Confirmation Statement, click Confirmation Statement .

23. When finished, click Finish .

You will then see another review of what you have selected.

If you want to make any changes, click Update Benefits and follow from step 11. You're Done!

Note: You can make changes to updates as changes are accepted throughout the Open Enrollment Period.

OPEN ENROLLMENT INSTRUCTIONS 09/01/2009 - 08/31/2010 *(cont'd)*

You must complete and return an application if you do not enroll using Oracle Self Service and are currently not covered under the City Plan, changing coverage, adding a dependent or are required to provide documentation for a full-time student. Print your *name* and *social security number* on all documents submitted. Telephone numbers are also required and should be listed on your application. Include your Medicare card if you are covered by Part A and Part B of Medicare. ***Return your Open Enrollment application by July 22, 2009.*** You should contact the carriers to insure your physicians are participating providers in your plan.

The Open Enrollment Application is the document retirees must use to enroll in health and/or optional dental and/or vision insurance and to decline health and/or dental and/or vision insurance for 09/01/2009 through 08/31/2010. Be sure to initial the choices you elect on your Application Form.

I. EDUCATE YOURSELF ON YOUR BENEFIT PLAN OPTIONS

- Review information in this booklet about each of the health, dental, vision and life plans available to retirees
- Call the carrier/HMO if you have questions
- Attend an Open Enrollment Meeting and speak to carrier/HMO representatives
- Contact the DHR Insurance Division at **(404) 330-6036** for further information

II. YOU MAY ENROLL ONLINE USING EMPLOYEE SELF SERVICE OR YOU MAY FILL OUT YOUR OPEN ENROLLMENT APPLICATION FORM. An Enrollment Application is included with your Benefits Booklet. Assistance in completion of the application will be available in the City Hall Atrium July 9th, 11th and 16th. Full instructions for completion of the Open Enrollment Application can be found in the back pocket behind your application.

III. IMPORTANT POINTS TO REMEMBER:

- **If you fail to provide the required documentation, your dependent(s) will not be covered.** It is the retiree's responsibility to confirm the dependent's coverage. Notifications are not sent to retirees who fail to submit the required documentation.
- If you do not provide a registrar's Full-Time Student Statement to continue insurance for children over 19 years of age, the dependent's coverage will end August 31, 2009.
- Your eligible dependents may only be insured with the same insurance carrier/benefit plan you have chosen for yourself.
- Remember to put your name and Social Security number on all documentation and staple the documentation to the application/verification form if you are making any changes.
- You will be able to print confirmation of coverage online.
- Check your payroll statement for the coverage on file with the City and the deduction taken. Notify the DHR Insurance Division or your departmental payroll clerk/HR representative of any discrepancies.

Name and Address Changes

If your name or address has changed, please submit that information to the Pension Division on the form provided in this booklet.

Carrier booklets are available, at the Open Enrollment Meetings, or at the DHR Insurance Division, Room 2107, 68 Mitchell St., S.W., Atlanta, GA 30303.

BLUECHOICE POS PLAN
BENEFITS SUMMARY 09/01/2009 - 08/31/2010

In addition to copayments, members are responsible for deductibles, as described below.
Please review the deductible information to know if a deductible applies to a specific covered service.

Members are also responsible for all costs over the plan maximums.
Plan maximums and other important information appear in *italics*.

Each member enrolling in this plan must list a primary care physician on the enrollment application.
When using out-of-network providers, members are responsible for any difference between the allowed amount and actual charges, as well as any copayments and deductibles.

DEDUCTIBLES, MAXIMUMS, ETC.	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Calendar Year Deductible: *one for retiree, one for spouse, one for all eligible children combined*		
– Individual	None	$300
– Family	None	$900
Coinsurance/Copayments	Plan pays 100%; Member pays copayments as required	Plan pays 70% after deductible; Member pays 30% after deductible
Lifetime Maximum	Unlimited	$1,000,000
Out-of-Pocket Calendar Year Maximum*		
– Individual	None	$2,000
– Family	None	$6,000

**Maximum of three (3) per family* (one for retiree, one for spouse and one for all eligible children combined). The following do not apply to out-of-pocket maximum: deductibles, copayment amounts, non-emergency room copayments, non-covered items and coinsurance for behavioral health/substance abuse. Out-of-Pocket limits are accumulated separately for in-network and out-of-network services.

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Office Visits: Preventive Care		
• Well-child care, immunizations	$15 copayment	Plan pays 70% after deductible
• Periodic health examinations	$15 copayment	Not covered
• Annual gynecology examination (No PCP referral required – Must use in-network provider for in-network benefits)	$25 copayment	Plan pays 70% after deductible
• Adult Annual Physical	$15 copayment PCP (maximum benefit $500) $25 copayment Specialist (maximum benefit $500)	Plan pays 70% after deductible (maximum benefit $500)
• Prostate screening	$25 copayment	Plan pays 70% after deductible
Illness or Injury		
• Primary Care Physician (PCP) office visit (includes lab, radiology and office surgery)	$15 copayment	Plan pays 70% after deductible
• Primary care physician after hours visit	$25 copayment	Plan pays 70% after deductible
• Specialty care physician office visit (PCP referral required)	$25 copayment	Plan pays 70% after deductible
• Second surgical opinion (PCP referral required)	$25 copayment	Plan pays 70% after deductible
• Allergy care (office visit, testing, serum and allergy shots)	$25 copayment	Plan pays 70% after deductible

BLUECHOICE POS PLAN
BENEFITS SUMMARY09/01/2009 - 08/31/2010
(cont'd)

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
• Maternity physician services (prenatal, delivery, postpartum)	$25 copayment at first office visit	Plan pays 70% after deductible
• Vision care services provided by a network ophthalmologist or optometrist for treatment of acute conditions (No PCP referral required)	$25 copayment	Plan pays 70% after deductible
• Services provided by network dermatologists (No PCP referral required)	$25 copayment	Plan pays 70% after deductible
Emergency Room Services		
• Life-threatening illness, serious accidental injury or with a PCP referral	$75 copayment *(waived if admitted)*	$75 copayment *(waived if admitted)*
• Non-emergency use of the emergency room	Not covered	Not covered
Inpatient Services		
• Daily room, board and general nursing care at semi-private room rate; ICU/CCU; other medically necessary hospital charges such as diagnostic x-ray and lab services; newborn nursery care	Per admission copayment $200	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100% after copayment	Plan pays 70% after deductible
Outpatient Services		
• Surgery facility/hospital charges (outside a physician's office)	Plan pays 100% after $100 copayment	Plan pays 70% after deductible
• Diagnostic X-ray and lab services	Plan pays 100%	Plan pays 70% after deductible
• Physician services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	Plan pays 100%	Plan pays 70% after deductible
Therapy Services	**Calendar year visit limits are combined between in-network and out-of-network**	
• Speech Therapy	$25 copayment; 20-visit calendar year maximum	Plan pays 70% after deductible; 20-visit calendar year maximum
• Physical, occupational therapy	$25 copayment; 20-visit calendar year maximum	Plan pays 70% after deductible; 20-visit calendar year maximum
• Respiratory therapy	Plan pays 100%; 30-visit calendar year maximum	Plan pays 70% after deductible; 30-visit calendar year maximum
• Radiation therapy, chemotherapy	Plan pays 100%	Plan pays 70% after deductible

BLUECHOICE POS PLAN
BENEFITS SUMMARY 09/01/2009 - 08/31/2010
(cont'd)

COVERED SERVICES	IN-NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
Mental Health/Substance Abuse	**No Primary Care Physician referral required. Services must be authorized by Blue Cross/Blue Shield of Georgia Behavioral Health at (800) 368-0766**	
• Inpatient (45 days per cal. yr. max.)	$200 copayment; Plan pays 100%	Plan pays 70% after deductible
• Outpatient (max. 40 visits per cal yr.)	$25 copayment; Plan pays 100%	Plan pays 70% after deductible
Other Services		
• Skilled nursing facility (100 days maximum)	$200 copayment; Plan pays 100%	Plan pays 70% after deductible
• Home HealthCare (40 visits per cal. yr. max.)	Plan pays 100%	Plan pays 70% after deductible
• Hospice Care *($7,500 maximum)*	Plan pays 100%	Plan pays 100%
• Ambulance	$100 copayment; Plan pays 100%	Plan pays 70% after deductible
Prescription Drugs		
To receive maximum coverage, have your prescriptions written by a network physician and filled at one of the pharmacies in our network. These include certain local independent pharmacies, as well as many national chain pharmacies: Bi-Lo, CVS, Eckerd, Kmart, Kroger, Publix, Save-Rite, Walgreens, Wal-Mart, Winn-Dixie.	Unless otherwise indicated in the Summary Plan Description, each prescription has a 30-day supply limit. Each mail order maintenance prescription has a 90–day supply limit.	
Retail:		
Generic	$10	Plan pays 70% after the deductible for covered prescriptions at non-participating pharmacies.
Brand Formulary	$25	
Brand Non-Formulary	$40	
Mail order: (Maintenance drugs only)		**NO MAIL ORDER PRESCRIPTIONS ARE AVAILABLE OUT-OF-NETWORK**
Generic	$20	
Brand Formulary	$50	
Brand Non-Formulary	$80	
Vision	The coverage will be limited to one (1) eye examination for corrective lenses per member in a 12 month period, (corrective lenses is intended to include contacts as well as glasses). Office visit co-payment should be the same as for any other specialist $25.00 in-network and 70% of UCR, after the deductible, out-of-network. The City will not cover lenses, frames, disposable or hard contact lenses and POS Members will be encouraged to utilize the BCBS discounted vision program.	

For a full disclosure of all benefits, exclusions and limitations please refer to your Summary Plan Description.

Blue Cross/Blue Shield of Georgia will designate a Primary Care Physician (PCP) for you if you do not list one on your Enrollment Application. You may change your PCP by notifying Blue Cross/Blue Shield of Georgia. If notification is received prior to the 25th, the PCP will change the 1st of the following month. Notification after the 25th will delay the change a month.

BLUECHOICE POS PLAN
BENEFITS SUMMARY 09/01/2009 - 08/31/2010
(cont'd)

Primary Care Physician

A primary care physician, or PCP, is a doctor who specializes in family or general practice, internal medicine or pediatrics and participates in the BlueChoice Option network. Each BlueChoice Option member must select a PCP. Your PCP is responsible for providing or coordinating necessary care for you 24 hours per day, 7 days a week. For additional medical information call BlueChoice On-Call, available 24 hours per day, 7 days a week.

In-Network versus Out-of-Network

As a BlueChoice Option member, you have the ability to receive services either from providers in the BlueChoice Option network or outside this network. Generally, you will pay less out of your own pocket if you elect in-network services.

- ***In-Network Services*** are those services that are either provided or coordinated by your PCP. Some services do not require PCP coordination. Please keep in mind that even though a referral is not required for certain services, you must select a provider from the network directory to receive in-network benefits. Services that do not require a PCP referral include:
  - *OB/GYN* services for the treatment of an obstetrical or gynecological-related condition.
  - *Covered Vision Care Services* – from a network ophthalmologist or optometrist (Routine vision services may not be covered under your policy – if you do not know if you have routine vision coverage, please call customer service at **(800) 368-0766**).
  - *Dermatological care* for skin-related conditions.
  - *Mental Health or Substance Abuse benefits* – You may contact Blue Cross/Blue Shield of Georgia Behavioral Health directly at **(800) 368-0766**, without contacting your PCP.

Pre-Existing Condition Limitation and Credit for Prior Coverage

There is no pre-existing condition limitation.

Emergencies

If you have a medical emergency, call 911 or proceed immediately to the nearest hospital emergency room. A "medical emergency" is defined as, "a condition or recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in their health being in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ."

Prescription Drugs

BlueChoice Option offers prescription drug coverage through a pharmacy network that includes many national pharmacy chains and select local pharmacies. Coverage is provided according to our preferred drug formulary for prescriptions written by a network physician and filled at a network pharmacy. Out-of-network prescriptions are also subject to the preferred drug formulary.

Summary of Limitations and Exclusions

Your *Summary Plan Description* will provide you with complete benefit coverage information. Some key limitations and exclusions, however, are listed below:

- Care or treatment that is not medically necessary
- Cosmetic surgery, except to restore function altered by disease or trauma
- Dental care and oral surgery; except for accidental injury to natural teeth, treatment of TMJ and extraction of impacted teeth
- Routine physical examinations necessitated by employment, foreign travel or participation in school athletic programs.
- Occupational related illness or injury
- Treatment, drugs or supplies considered experimental or investigational
- Surgical or medical care for: artificial insemination, in-vitro fertilization, reversal of voluntary sterilization, radial keratotomy, learning disabilities, mental retardation, hyperkinetic syndrome or autistic disease of childhood
- Smoking cessation products

Prior Authorization

Your PCP must coordinate most in-network services. For in-network services, your PCP (or the specialist to whom you were referred by your PCP) will be responsible for ensuring

that any surgical procedures or inpatient admissions obtain the necessary prior authorization. For out-of-network services, you should be sure that Blue Cross Blue Shield Healthcare Plan of Georgia has authorized the following procedures prior to these services being rendered:

- Home health care services
- All outpatient surgery, including laproscopic and arthroscopic procedures
- Durable Medical Equipment over $250
- MRIs
- EMGs
- All scopes, including endoscopy and colonoscopy
- Myelography
- Cardiac catheterization

Note: This list is subject to change.

If you receive out-of-network treatment and prior authorization was not obtained, all charges will be denied. You, the member, will be responsible for all charges.

Vision

The coverage will be limited to one (1) eye examination for corrective lenses per member in a 12 month period, (corrective lenses is intended to include contacts as well as glasses). Office visit co-payment should be the same as for any other specialist $25.00 in-network and 70% of UCR, after the deductible, out-of-network.

The City will not cover lenses, frames, disposable or hard contact lenses and POS Members will be encouraged to utilize the BCBS discounted vision program.

Additional Information

Should you need additional information, the resources are your *Provider Directory/Member Guide* and your *Summary Plan Description*. You may also visit our web site at **www.bcbsga.com** for more information. If you have specific questions that require an answer from our representatives, please call one of the following numbers:

- Customer Service ..... **(800) 368-0766**
- Blue Cross/Blue Shield of Georgia Behavioral Health (Mental Health/Substance Abuse Services) ..... **(800) 368-0766**
- BlueChoice On-Call ..... **(888) 724-2583**

See Summary Plan Description for Complete Details

It is important to keep in mind that this material is a brief outline of benefits and covered services and is not a contract. Please refer to your *Summary Plan Description* for a complete explanation of covered services, limitations and exclusions.

Condition Management Programs

It really doesn't matter if you or someone on your health benefits plan just found out, or if you've known for a while, we know managing a chronic health condition can sometimes be tricky.

And, if you're trying to manage a health condition such as Asthma, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Coronary Artery Disease (CAD) or Diabetes, you'll probably agree that having access to new medical information and advice, tips and online tools specifically designed to help you manage your condition is invaluable. Neonatal Intensive Care Unit (NICU) and Maternity Management are also included. And, that's how using our Condition Management programs can come in handy!

What Is It and What's Included?

Our Condition Management programs are a service where you can talk with one of our registered nurses 24/7, or you can access information online to find ways to better manage your condition.

When you participate in this program, you have access to:

- Health evaluations and consultations as needed, to help you manage your condition
- Educational materials on prevention, self-monitoring charts, condition-specific care diaries and self-care tips

You'll also gain peace-of-mind because you'll know you have the tools and information you need to begin, or continue, taking control of your health condition. That alone is worth the price of admission; however, this is a free program!

What Else?

When you receive something you need, you're happy. And, we believe you'll be happy with the information and tools available in our Condition Management programs. So, don't delay the happy feelings! Give us a call at **(800) 638-4754** to enroll.

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010

Welcome to SmartValue, Available Through Blue Cross/Blue Shield of Georgia.

SmartValue is a Medicare Advantage Private Fee For Service (PFFS) Plan that provides Medicare eligible individuals with an alternative to the Original Medicare program. To elect SmartValue coverage, you must be enrolled in both Medicare Part A and B and reside in the service area covered by this plan.

SmartValue is a PFFS plan with a Medicare contract. Blue Cross/Blue Shield of Georgia (BCBSGA) has agreed to provide the health care services covered by Original Medicare. The government, in turn, assigns your Medicare benefits to your Medicare Advantage SmartValue Plan for Group Retirees.

SmartValue:

- is NOT a Medicare Supplemental Plan.
- is NOT a Medigap Plan.

Freedom to Choose Nationwide

SmartValue is a Private Fee For Service Health Plan. A private fee for service plan allows you to receive health care services from any licensed doctor you choose. As long as your doctor participates in Original Medicare and is willing to accept the terms and conditions of SmartValue, the choice is yours. With direct access to doctors and specialists, your course of treatment can be decided by those you trust most.

An Important Note About This Plan

A Medicare Advantage Private Fee For Service Plan works differently than your existing plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, or otherwise agree to treat you, you will not be able to receive covered services from them under this plan. Provider disclosure concerning the plan's terms and conditions is located in the back of the SmartValue pre-enrollment booklet.

SmartValue Plans Include All the Benefits for Medicare Covered Services and More.

- Doctor Office Visits
- Inpatient Hospital Services
- Outpatient Hospital Services
- Emergency Care Services
- Ambulance Services
- 24-Hour Nurse Helpline
- Durable Medical Equipment
- Diagnostic Tests – including X-Rays and Laboratory Services
- Medicare Part D Prescription Coverage

Please note that in order to use the Medicare Part D prescription coverage that is being offered to you, you will need to use a network pharmacy unless you are dealing with an emergency situation. BCBSGA partners with thousands of pharmacies all across the country and an abbreviated list of the top chain pharmacies will be included with the enrollment brochure you will receive from BCBSGA.

SmartValue plans do not simply mirror Medicare coverage. They go way beyond Medicare basics to also include access to important resources that can support you when you've got health care decisions to make. And even some extras thrown in like discounts.

It's all part of an integrated approach BCBSGA developed called the SeniorCentric 360˚ Health Program that not only helps pay for your medical bills, but also gives you the tools and support you need to make the most of your coverage.

The SeniorCentric 360˚ Health Program Includes:

- Preventive care services that can help you – feel healthier or help treat problems at their earliest stages.
- Care management for members dealing with chronic conditions such as asthma, diabetes or certain heart ailments.
- Care management for members dealing with multiple conditions.
- A dedicated nurse line available to you 24 hours a day, 7 days a week.
- Access to discounts on health clubs, weight management programs and more.

Coverage That Travels With You

Did someone say vacation? Retirement is all about going where you want to go, when you want to go. And, as a SmartValue plan member, you'll enjoy the flexibility of plan coverage that is accessible throughout the United States. As a reminder, when traveling and accessing a new provider, be sure to verify the provider accepts SmartValue plan established terms to ensure your services will be covered by your plan benefits.

*Valuable Extras for Added Support

Please note: the valued added products and services described below are neither offered nor guaranteed under our contract with the Medicare program. In addition, they are not subject to the Medicare appeals process. Any disputes regarding these products and services may be subject to the Blue Cross/Blue Shield of Georgia grievance process.

***24-Hour Nurse Information Line and HealthLine Audiotape Library**

Health concerns don't always occur during times when your health care professional's office is open. The 24-hour Nurse Information Line is a convenient alternative that you can call any time of the day or night, 365 days a year. Helpful and supportive nurses will guide you on over-the-counter remedies or let you know when you need to seek care from a health care professional.

Just want to get some information on a particular health-related topic, but don't want to speak to a nurse? You can do that too by calling the HealthLine Audiotape Library with access to prerecorded content on hundreds of health related topics.

***Silver&Fit Education and Exercise Program**

Designed exclusively for SmartValue members, Silver&Fit gives you access to weight management programs, personal trainers and discounts on fitness club memberships. There's also a dedicated Silver&Fit website and a home kit option for members who need or prefer to exercise in the comfort of their home.

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

Exclusions and Limitations

As with any health plan, specific exclusions and limitations are assigned to the plan benefits being offered to you. Full disclosure of these exclusions and limitations will be provided in the enrollment brochure you'll be receiving from BCBSGA.

Enrolling in SmartValue Coverage

Enrolling in SmartValue plan coverage is easy because there are no physicals required up front and there are no limitations to your coverage if you are already dealing with pre-existing medical conditions.

An Important Note About Part D Drug Coverage

The Part D prescription drug coverage being offered to you is only available to you if you are also electing the Medicare Advantage health plan coverage. You may only be enrolled in one Part D plan. If you're currently enrolled under another Part D plan, you will need to disenroll from that plan.

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**, 24 hours a day/7days a week;
- the Social Security Administration at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday thru Friday. TTY/TDD users should call, **1-800-325-0778**; or your state Medicaid office.

Questions Before You Enroll? Get to Know the First Impressions Welcome Center

The First Impressions Welcome Center is a phone line, staffed by helpful Blue Cross/Blue Shield of Georgia representatives that will take the time to answer your questions and talk with you about the SmartValue Plan.

First Impressions Welcome Center
(866) 657-4970
(800) 425-5705 (for TTY/TDD users)
Monday through Friday
8 a.m. to 9 p.m. Eastern Time

If you need this document in an alternate format, please contact the First Impressions Welcome Center.

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
INPATIENT SERVICES	
Inpatient Hospital Care Hospital days are unlimited. Covered services include, but are not limited to, the following: • Semi-private room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care unite (such as intensive or coronary care units. • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy and speech therapy services. • *Under certain conditions, the following types of transplants are covered:* corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell and intestinal/multivisceral. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services.	$250 copayment per admission Request pre-notification by calling customer service 3 inpatient copayments per calendar year You may go to any doctor, specialist or hospital that accepts the plan's payment.
Inpatient Mental Health Care Includes mental health care services that require a hospital stay. There is a 190 day lifetime limit for inpatient services in a psychiatric hospital. The lifetime limit days used under the Original Medicare program will count towards the 190 day lifetime limit days when enrolling in a Medicare Advantage plan. The 190 day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	$250 copayment per day Request pre-notification by calling customer service Copayment will be charged for 1-10 days.

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
INPATIENT SERVICES *(cont'd)*	
Skilled Nursing Facility Care Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital of a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row. Covered services include, but are not limited to, the following: • Semi-private room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Physical therapy, occupational therapy and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	$50 copayment per day Request pre-notification by calling customer service Copayment will be charged for 1-10 days.
Inpatient Services **(when the SNF days are not covered or are no longer covered)** • Physician services. • Tests (like x-ray or lab tests). • X-ray, radium and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative of malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back and neck braces; trusses and artificial legs, arms and eyes including adjustments, repairs and replacements required because of breakage, wear, loss or a change in the patient's physical condition. • Physical therapy, speech therapy and occupational therapy.	After your SNF day limits are used up, physician services and other medical services will still be covered by SmartValue.

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
INPATIENT SERVICES *(cont'd)*	
Home Health Care • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy and speech therapy. • Medical social services. • Medical equipment and supplies.	$0 copayment per visit
Hospice Care • Drugs for symptom control and pain relief, short-term respite care and other services not otherwise covered by Medicare. • Home care.	$0 copayment for Medicare approved services When you enroll in a Medicare-certified Hospice, services are paid by Medicare
OUTPATIENT SERVICES	
Physician Services, Including Doctor Office Visits • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis and treatment by a specialist. • Second opinion by another plan provider prior to surgery. • Outpatient hospital services. • Non-routine dental care provided by a dentist (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones and extraction of teeth to prepare the jaw for radiation). • Treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor. • Excess Charge – Medicare pays up to 115% of charges if doctor does not accept Medicare assignment.	$15 copayment for visits to professional providers No additional cost to the member
Chiropractic Services • Manual manipulation of the spine to correct subluxation.	$15 copayment
Podiatry • Treatment of injuries and disease of the feet (such as hammer toe or heal spurs). • Routine foot care for member with certain medical conditions affecting the lower limbs.	$15 copayment
Outpatient Mental Health Care (Including Partial Hospitalization Services) Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant or other mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$15 copayment
Outpatient Substance Abuse Services	$15 copayment

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
OUTPATIENT SERVICES *(cont'd)*	
Outpatient Surgery	$50 copayment
Ambulance Services Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home and services dispatched through 911 where other means of transportation could endanger your health.	$0 copayment
Emergency Outpatient Care • Emergency care is available on a world-wide basis.	$50 copayment, waived if admitted within 72 hours
Urgently Needed Care • Urgent care is available on a world-wide basis.	$15 copayment
Outpatient Rehabilitation Services (physical therapy, occupational therapy, cardiac rehabilitation and speech and language therapy) Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery and/or have stable angina pectoris.	$15 copayment
Durable Medical Equipment (DME) and Related Supplies This includes wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer and walker.	$0 copayment
Prosthetic Devices and Related Supplies (Other than Dental) Which Replace a Body Part of Function These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" section for more detail.	20% coinsurance on all Medicare approved prosthetics
Diabetes Self-monitoring, Training and Supplies For all people who have diabetes (insulin and non-insulin users) • Blood glucose monitor, blood glucose test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors. • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or insert. • Self-management training is covered under certain conditions. • *For persons at risk of diabetes:* fasting plasma glucose tests up to twice a year.	$10 copayment for each 30 day supply of glucose test strips, lancet devices and lancets and glucose control solutions for checking the accuracy of test strips and monitors $0 copayment for blood glucose monitor and therapeutic shoes $15 copayment for management training $0 copayment for fasting plasma glucose tests

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
OUTPATIENT SERVICES *(cont'd)*	
Medical Nutrition Therapy For people with diabetes, renal (kidney) disease (but not on dialysis) and after a transplant when referred by your doctor.	$0 copayment for each Medicare covered visit
Outpatient Diagnostic Tests and Therapeutic Services and Supplies • X-rays. • Hi-tech Radiology. (PET Scans, CAT Scans and Nuclear Radiology) • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood – including storage and administration. Coverage of whole blood and package red cells begins only with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used.	$0 copayment for each Medicare covered radiation therapy and chemotherapy treatment $0 copayment for each Medicare approved clinical/diagnostic lab test $15 copayment for each x-ray
PREVENTIVE CARE AND SCREENING TESTS	
Abdominal Aortic Aneurysm Screening A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	$0 copayment
Bone Mass Measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss or determine bone quality, including a physician's interpretation of the results.	$15 copayment
Colorectal Screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. For people at high risk of colorectal cancer, the following is covered: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	$0 copayment
Immunizations • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine. • Other vaccines if you are at risk.	$0 copayment

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
PREVENTIVE CARE AND SCREENING TESTS *(cont'd)*	
Mammography Screening You can get this service on your own, without a referral from your provider. • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	$0 copayment
Pap Smears, Pelvic Exams and Clinical Breast Exams For all women – Pap tests, pelvic exams and clinical breast exams are covered once every 24 months. If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age – one Pap test every 12 months.	$15 copayment
Prostate Cancer Screening Exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	$0 copayment
Cardiovascular Disease Testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) every five years.	$0 copayment
OTHER SERVICES	
Physical Exams Routine physical exams (limited to one exam per year) are performed without relationship to treatment or diagnosis for specific illness, symptom, complaint or injury and are not required by third-party (i.e., insurance companies, business establishments, governmental agencies). Routine lab and x-ray ordered in conjunction with the physical exam is covered.	$15 copayment
Renal Dialysis (Kidney) • Outpatient dialysis treatments. • Inpatient dialysis treatments (if you are admitted to a hospital for special care. • Self-dialysis training (includes training for you and others for the person helping you with your home dialysis treatments). • Home dialysis equipment and supplies. Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies and check your dialysis equipment and water supply).	$0 copayment for outpatient dialysis $0 copayment for inpatient dialysis $0 copayment for self dialysis training $0 copayment for home dialysis equipment and supplies

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
OTHER SERVICES *(cont'd)*	
Prescription Drugs Covered Under Your Medical Plan (Part B Drugs) "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services. SmartValue also covers some drugs that are "usually not self-administered" even if you inject them at home. • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by SmartValue. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectable osteoporosis drugs – if you are homebound or have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	$0 copayment Please refer to your Drug EOC for your prescription drug benefits.
ADDITIONAL BENEFITS	
Hearing Services • Diagnostic hearing exams. • Routine hearing exams are covered once every two years.	$15 copayment $50 maximum benefit
Vision Care	
• Outpatient physician services for eye care.	$15 copayment for eye care
• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes and African-Americans who are age 50 and older: glaucoma screening once per year.	$0 copayment for glaucoma screening
• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	$0 copayment for glasses/contacts following cataract surgery
• Routine vision exams limited to one exam per year.	$15 copayment for routine vision exams

BLUE CROSS/BLUE SHIELD RETIREE SMARTVALUE USER GUIDE (MEDICARE COVERED) 09/01/2009 - 08/31/2010 *(cont'd)*

COVERED SERVICES	WHAT YOU MUST PAY FOR THESE COVERED SERVICES
ADDITIONAL BENEFITS *(cont'd)*	
Foreign Travel Emergency and Urgently Needed Care Emergency or urgent care services while traveling outside the United States during a temporary absence of less that 6 months. Outpatient copayment is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care. • Urgent care. • Inpatient care. 60 days per lifetime.	$50 copayment for Emergency Care $15 copayment for Urgent Care $250 deductible 20% to $50,000 lifetime maximum for inpatient care
Annual Out-of-Pocket Maximum All coinsurance, copays and deductibles listed in this benefit summary are accrued toward the medical plan out-of-pocket maximum with the exception of the foreign travel deductible and emergency and urgently needed care co-insurance specific to foreign travel. Prescription drug plan deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$3,350

PRESCRIPTION DRUG BENEFITS	
Formulary	**Premier 4 Tier**
Mandatory Generic	**No**
Deductible	**$0**
COVERED SERVICES	**WHAT YOU PAY**
Initial Coverage	
Below is your payment responsibility from the time you meet your deductible, if you have one, until the cost paid by you for your prescriptions reaches your True Out-of-Pocket cost of $4,350.00.	
Retail Pharmacy	**per 30-day supply**
• Generics	$10 copay
• Select Generics	$0 for Select Generics
• Preferred Brands, Vaccines	$20 copay
• Non-Preferred Brands	$40 copay
• Non-Specialty and Specialty Injectables, Specialty Drugs (Generic and Brand)	20% up to a maximum of $100 (Specialty limited to a 30-day supply)
Typically retail pharmacies dispense a 30-day supply of medication. Some of our retail pharmacies can dispense up to a 90-day supply of medication. If you purchase more than a 30-day supply at these retail pharmacies, you will need to pay one copay for each full or partial 30-day supply filled. For example, if you order a 90-day supply, you will need to pay three 30-day copays. If you get a 45-day or 50-day supply, you will need to pay two 30-day copays.	
Mail Order Pharmacy	**per 90-day supply**
• Generics	$20 copayment
• Select Generics	$0 copay for Select Generics
• Preferred Brands, Vaccines	$40 copayment
• Non-Preferred Brands	$80 copayment
• Non-Specialty and Specialty Injectables, Specialty Drugs (Generic and Brand)	20% up to a maximum payment of $200 (Specialty limited to a 30-day supply.)
If you purchase drugs at Retail or Mail Order Pharmacies that are not listed in our participating pharmacy directory, you will be responsible for all amounts over our negotiated cost. If you need an emergency supply of drugs and you are not near a Retail Pharmacy in our participating pharmacy directory, you will not be responsible for amounts over our negotiated costs.	

KAISER PERMANENTE RETIREE HMO USER GUIDE (NON-MEDICARE ELIGIBLE) 09/01/2009 - 08/31/2010

Connect To Your Health

With Kaiser Permanente, you'll have access to a wide variety of resources to help you get healthy and stay healthy – mind, body and spirit. Join a health class at your local medical center, where you can learn how to lower your cholesterol, manage your asthma, do yoga and more. Browse your newsletters to keep you up-to-date on the latest health news and advice. Create an online action plan to help you beat stress, lose weight, eat better or stop smoking. Connect to your medical record online and view your ongoing health conditions, lab results, past office visits and other online features. With everything we have to offer, a healthier life is within your reach.

Where do I receive medical Care?

When you join Kaiser Permanente, you pick your own personal physician from the group of doctors practicing at our medical centers, or from a network of affiliated private-practice doctors who practice in their own offices all over town. Currently, Kaiser Permanente has 16 conveniently located medical centers throughout metro-Atlanta: Alpharetta, Brookwood at Peachtree, Cascade, Crescent, Cumberland, Forsyth, Glenlake, Gwinnett, Henry, Panola, Southwood, TownPark, West Cobb, Stonecrest and North Gwinnett medical centers.

There are also private practice Affiliated Community Physicians available within the Kaiser Permanente service area. These physicians practice in their own offices. For a listing of the providers covered under the Kaiser Permanente plan, please refer to the HMO Physician directory or visit us online at ww.kp.org.

How do I choose or change my primary care physician?

We ask you to choose a personal physician upon enrollment so that you and your doctor can develop a partnership and work together to make sure you get the quality care you deserve. Your personal physician will guide and coordinate any care you receive in the hospital or from specialists. And having one doctor who arranges your care and knows your medical history helps you get the right care from the right people. The relationship you build with your personal physician can help you achieve and maintain both good health and good spirits.

You may choose a physician in family medicine, general practice, adult medicine or pediatrics/adolescent medicine as a personal physician. (Refer to the *Kaiser Permanente HMO Physician Directory* in your enrollment packet for specifics.)

Simply call our Customer Service Department at **(404) 261-2590** locally or **(888) 865-5813** long distance.

How do I make an appointment?

It's really easy. There is one number to call to make or cancel appointments, speak with an advice nurse, or access after-hours urgent care – regardless of which Kaiser Permanente Medical Center you use. Call the Health Line at **(404) 261-2590** locally or **(888) 865-5813** long distance.

If your personal physician is one of our Affiliated Community Physicians, call his or her office directly to make an appointment.

To schedule or cancel appointments, you may call Monday through Friday from 7 a.m. to 7 p.m. The Health Line is open to speak with an advice nurse 24 hours a day, seven days a week.

What if I need to see a specialist?

When you select a personal physician, keep in mind that your choice will determine which specialists are available to you. Your personal physician has an established relationship with a specific group of specialty care doctors with whom he or she works with on a regular basis. By referring only to a certain group of specialists, your physician is better able to coordinate and oversee your care. You must get a referral from your personal physician in order to see a specialist. If you change your personal physician, the specialists available to you may also change.

As a Kaiser Permanente member, you have direct access to OB/GYNS, Dermatologists, Ophthalmologists, Optometrists, Psychiatrists and Behavioral Specialists. No referral is required associated with emergency services.

What if I need to be admitted to the hospital?

Kaiser Permanente is affiliated with some of Atlanta's most prestigious hospitals. The personal physician you choose will determine the hospital to which you will be admitted. The hospitals used for most inpatient care are: Children's Healthcare of Atlanta at Scottish Rite, Emory Eastside Medical Center, Northside Hospital, Piedmont Hospital, Rockdale Hospital, Southern Regional Medical Center, WellStar Cobb Hospital, WellStar Douglas Hospital, WellStar Kennestone Hospital, and WellStar Paulding Hospital.

Get Connected

With Kaiser Permanente, you have secure, 24-hour access to portions of your health record online at kp.org. You also have increased access to your doctor and more tools to help you take a more active role in your health.

With these new time-saving features, you can:

- E-mail your doctor's office
- View certain lab test results
- Review past office visit information and future appointments
- Monitor your ongoing health conditions
- Access the health records of your children
- View your allergies

What should I do if I need emergency care?

If you have an emergency, call 911 or go to the nearest emergency room.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

If you are hospitalized, you should call (or have someone else call) the Kaiser Permanente Health Line – **(404) 261-2590** locally or **(888) 865-5813** long distance – to notify us of your hospital admission as soon as you can within 24 hours of your admission. This will allow us to consult with the physician providing your care and to coordinate further medical care.

You will pay a $100 copayment for emergency room services. (Emergency fees are waived if you're admitted.) Students attending school outside of the Kaiser Permanente service area will be covered for up to $500 for follow-up care associated with emergency services.

Do I fill out claim forms?

There are no claim forms required if care is provided, prescribed, or directed by a Kaiser Permanente physician. If there is a copayment, coinsurance, or deductible, you will be expected to pay at the time you receive the services.

If you have any questions about claims, please call a Claims Services Representative at **(404) 261-2590**.

What if I have additional questions?

Call Customer Services at **(404) 261-2590** locally or **(888) 865-5813** long distance. You can also visit our website at www.kp.org.

KAISER PERMANENTE RETIREE HMO USER GUIDE (NON-MEDICARE ELIGIBLE) 09/01/2009 - 08/31/2010 *(cont'd)*

CATEGORY	09/01/2009 - 08/31/2010 – HMO PLAN DESIGN
Deductible	Not applicable
Office Visits	$10 co-pay
Specialist	$30 co-pay
Out-patient Surgery	$100 co-pay, facility visits (inclusive of High-tech Radiology and Colonoscopy)
Maternity Out-patient	$30 co-pay 1st visit; then 100% thereafter
Pediatric Office Visit	$10 co-pay
Immunizations	$10 co-pay, (well child care covered @100% up to age 2)
Prescription Brand	$30 co-pay at Kaiser per 30 day supply; $36 co-pay at Rite Aid or Walgreens per 30 day supply
Prescription Generic	$10 co-pay at Kaiser per 30 day supply; $16 co-pay at Rite Aid or Walgreens per 30 day supply
Mail Order	90 days supply @ 2 times Kaiser RX co-pay
Inpatient Hospital Care	$200 co-pay per admission
Maternity In-patient	100% covered after $200 co-pay
Mental Health: Out-patient	$30 co-pay; unlimited visits
Ambulance	$100 co-pay
Emergency Room: In Plan	$100 co-pay
Emergency Room Out Plan	$100 co-pay
Urgent Care	$20 co-pay
Mental Health In-patient	$200 co-pay; unlimited days
Substance Abuse: Out-patient	$30 co-pay; unlimited visits
Substance Abuse: In-patient	Not covered
X-Rays & Lab work	100% covered if performed in a physicians office; $100 copay if performed in an out-patient hospital setting
Vision Eye Exam	$30 co-pay
Frames/Contact Lenses	Discounts available
Infertility	$30 co-pay for diagnosis; 50% for treatment.
Physical/Occupational Therapy (combined benefit)	$30 co-pay; limited to 20 visits
Speech Therapy	$30 co-pay; limited to 20 visits
DME Equipment	50% covered

KAISER PERMANENTE RETIREE HMO USER GUIDE (NON-MEDICARE ELIGIBLE) 09/01/2009 - 08/31/2010 *(cont'd)*

For the plan year beginning on September 01, 2009 and ending on August 31, 2010.

CITY OF ATLANTA - RETIREES	
PCP Selection	**If a PCP is not chosen upon enrollment, one will be assigned based upon the medical center closest to your home.**
Customer Services	**(404) 261-2590 (888) 865-5813 toll free Monday - Friday 8:30 a.m. until 9:00 p.m. Saturday, Sunday 8:00 a.m. until 2:00 p.m.**
Referral	**Self referral to Mental Health/Chemical Dependency, Dermatology and OB/GYN Care. All other speciality care services require prior authorization from your PCP.**

1 Some specific benefits have limitations.
2 Office visit copay may apply. Well-Child Visit: No Charge up to age 2.

Additional Information

- This benefit chart is a summary of the most frequently asked questions about benefits and their copayments. This is not a contract. Specific benefits, exclusions, and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage you will receive. In the case of a conflict between this benefit chart and the Evidence of Coverage, the Evidence of Coverage will prevail. For specific questions about coverage, please ask your employer's benefits office or contact Kaiser Permanente Customer Services at **(404) 261-2590**. Benefits are subject to approval by the Georgia Department of Insurance.
- The following is a partial list of exclusions and limitations under this plan: Services that are not medically necessary; Certain exams and other services required for obtaining or maintaining employment or participation in employee/retiree programs, or required for insurance or licensing, or on court order or for parole or probation; Cosmetic services; Custodial or intermediate care; Services that an employer is required by law to provide; Experimental or investigational services; Eye surgery, including laser surgery, to correct refractive defects; Services that a government agency is required by law to provide; Services for conditions arising from military service; Services related to the treatment of morbid obesity (except certain health education programs are covered); Routine foot care; Sexual reassignment services; Non-human or artificial organs or their implantation; Reversal of voluntary infertility; Transportation and lodging expenses; Conditions covered by workers' compensation or under employer liability law; Services not generally and customarily available in our service area.
- In order for Services to be covered, a Plan Physician must determine that the Services are medically necessary to prevent, diagnose, or treat your medical condition. With the exception of emergency services, all covered Services must be provided, prescribed, authorized, or directed by a Plan Physician. You must receive the Services at a Plan Facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. Certain covered services require pre-authorization by Medical Group.
- We use a formulary, which is a listing of medications that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary. For a copy of the formulary brochure or for more information about the exception process, contact Customer Services at **(404) 261-2590**.
- For details on the benefit and claims review and adjudication procedures, please refer to your Evidence of Coverage.
- Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of personal health and member identifiable information, including policies related to access to medical records. If you have questions about our policies and procedures to maintain the confidentiality of personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses personal information, please call Customer Services at **(404) 261-2590**.
- If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you or those of your eligible dependents who later have that coverage terminated for a reason other than fraud, misrepresentation or non-payment, may at that time be able to enroll in this health plan, provided that you request enrollment within 30 days after the other coverage ends. We may require sufficient proof of that other coverage and the reason for its termination. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

This plan summary is intended to only highlight some of the principal provisions of the plan. Please refer to the Group Agreement or Evidence of Coverage for further details of the plan or for specific limitations and exclusions.

Comparison of He

PLAN	PLAN DESCRIPTION	SERVICE AREA	
BlueCross/Blue Shield of Georgia SmartValue PFFS SmartValue (Post-65) with Parts A & B of Medicare	SmartValue is a Medicare Advantage Private Fee For Service (PFFS) Plan that provides Medicare eligible individuals with an alternative to the Original Medicare program. To elect SmartValue coverage, you must be enrolled in both Medicare Part A and Part B and reside in the service area covered by this plan. SmartValue is a PFFS plan with a Medicare contract. Blue Cross/Blue Shield of Georgia (BCBSGA) has agreed to provide the health care services covered by Original Medicare. The government, in turn, assigns your Medicare benefits to your Medicare Advantage SmartValue Plan for Group Retirees. A Medicare Advantage Private Fee for Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide health care services to you, except in emergencies. SmartValue: • is NOT a Medicare Supplemental Plan. • is NOT a Medigap Plan.	Freedom to choose nationwide. SmartValue is a Private Fee For Service Health Plan. A private fee for service plan allows you to receive health care services from any licensed doctor you choose. As long as your doctor participates in Original Medicare and is willing to accept the terms and conditions of SmartValue, the choice is yours. With direct access to doctors and specialists, your course of treatment can be decided by those you trust most.	$15 copayment for including medical a certified ambulatory treatment by a speci prior to surgery. $15 and disease of the fo medical conditions outpatient substance Medicare covered o services and supplie radiation therapy an ambulance services (such as a hospital) services dispatched transportation could copayment. $15 cop such as physical the $0 copayment for D devices and related body part or functio approved prosthetic
Kaiser Permanente – Senior Advantage HMO (Post-65) with Parts A & B of Medicare	Kaiser Permanente Senior Advantage plan combines the benefits of traditional Medicare with the resources, tools and people of Kaiser Permanente. You'll have one simple plan that gives you more benefits, more services and more convenience. All care must be provided or arranged by your personal Kaiser Permanente physician. Your Kaiser Permanente physician can be located in one of our 16 medical centers, or you may choose one of the affiliated physicians practicing in their own offices. To make your life easier, most of our medical facilities offer primary care, x-ray, lab and pharmacy services under one roof. If you can't come in during regular business hours, we also have locations with evening and weekend hours.	Barrow, Bartow, Butts, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Henry, Newton, Paulding, Rockdale, Spalding and Walton Counties.	Deductible: $0. Prir Speciality Care Pro 100% covered. Urg $50 copayment. An $200 copayment. O $50 copayment eve $10 copayment per diagnosis; 50% cov Maternity Outpatie thereafter. Maternit Immunizations: $10 thereafter). PT/OT/

(<u>Please Note:</u> This comparison is only intended as a general description of the plans available through the City of Atlant

ealth Care Plans (with Medicare Parts A & B) – R

DEDUCTIBLES/COPAYMENTS	HOSPITAL SERVICES	EMERGENCY ROOM SERVICE	PRESCRIPT
visits to professional providers. Office visits, nd surgical care in a physician's office or y surgical center. Consultation, diagnosis and ialist. Second opinion by another plan provider 5 copayment for Podiatry. Treatment of injuries eet, routine foot care for members with certain affecting the lower limbs. $15 copayment e abuse services. $0 copayment for each utpatient diagnostic tests and therapeutic es. $0 copayment for each Medicare covered d chemotherapy treatment. $0 copayment for includes ambulance services to an institution from an institution to another institution and through 911, where other means of d endanger your health. $50 outpatient surgery ayment for outpatient rehabilitation services erapy, cardiac rehabilitation and speech therapy. Durable Medical Equipment charges. Prosthetic supplies (other than dental) which replace a on is a 20% coinsurance on all Medicare s.	$250 copayment per admission. You may pre-notify by calling customer service. 3 inpatient copayments per calendar year maximum. You may go to any doctor, specialist or hospital that accepts the plan's benefits. Semi-private room (or private room if medically necessary). Costs of special care units (such as intensive or coronary care units).	$50 copayment, waived if admitted within 72 hours for Emergency Outpatient care. $15 copayment for Urgently need care. Care is available on a world wide basis.	**In-Network:** 30 day supply for Retail copayment generics, $20 $40 copayment non-form maximum payment of $1 90 day supply for Mail O generics, $40 copayment copayment non-formular maximum payment of $2 After you have paid $4,3 expenses, you pay the gr generic drugs and prefer drugs, $6.00 for all other coinsurance. **Out-of-Network:** You will need to pay the the pharmacy and submi reimbursement. You will the amount over the Med
mary Care Provider: $10 copayment. vider: $30 copayment. X-rays and Lab work: ent Care: $20 copayment. Emergency Room: mbulance: $100 copayment. Inpatient Hospital: Outpatient Hospital: $100 copayment. Allergy: r six months for maintenance allergy serum; injection. Infertility: $30 copayment for vered for treatment. DME: 80% covered. nt: $30 copayment first visit; then 100% y Inpatient: $200 copayment per delivery. 0 copayment (well-child care covered at 100% ST: $30 copayment; unlimited visits.	If admitted into the hospital, a $200 copayment applies. Semi-private rooms are covered by Kaiser Permanente. Private rooms are also covered if medically necessary. ICU, CCU and miscellaneous hospital charges are covered in full at participating hospitals after applicable copayment. Inpatient surgery is also covered at 100% after $200 copayment. Hospital stay must be authorized by a physician. Outpatient hospital services are covered at 100% after a $100 copayment. Outpatient services include, but are not limited to: outpatient surgery, colonoscopy, tubaligation and vasectomy. Participating hospitals: Children's Healthcare of Atlanta and Scottish Rite, DeKalb Medical Center - Central Campus, DeKalb Medical Center - Decatur Campus, DeKalb Medical Center at Hillandale, Emory Eastside Medical Center, Fayette Community Hospital, Newton Medical Center, Northside Hospital, Northside Hospital - Cherokee, Northside Hospital - Fayette and Piedmont Hospital.	Emergency care for illness or injury is covered 24 hours a day. If you have an emergency, call 911 or go to the nearest hospital. There is a $50 copayment per emergency room visit. If admitted, into the hospital, the emergency care copayment is waived and the inpatient hospital copayment of $200 applies. $100 copayment applies per ambulance trip. If urgent care services are required, a $20 copayment applies. If seeking services in one of the Kaiser Permanente regions outside of Georgia, you will have a 90 day visiting member benefit for services. Bills for services received outside of the service area must be submitted to Kaiser Permanente for payment within 90 days.	You have coverage for bo medications. You will rec supply of medication and supplies. Prescriptions m Kaiser Permanente or Rit **Pharmacy copayments -** **Retail -** - Generic: $10 copaymen $16 at Rite Ai - Brand: $30 copayment $36 at Rite Aid **Mail Order -** - Generic: $10 copaymen $16 at Rite Ai - Brand: $30 copayment $36 at Rite Aid All copayments are based of medication. For time released drugs, Depo-provera, the applic copay will be multiplied months the drug is effect

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Retirees 09/01/2009 - 08/31/2010

ION DRUGS	CARE OUTSIDE SERVICE AREA	PRE-EXISTING CONDITIONS	VISION CARE	MAJOR EXCLUSIONS
pharmacy, $10 copayment brand and nulary; 20% up to a 100 for injectable drugs. Order, $20 copayment brand and $80 y; 20% up to a 200 for injectable drugs. 50 of out-of-pocket eater of: $2.40 for red multi-source brand drugs or 5% full cost of the drug at t a claim for pay the copayment plus dicare allowed amount.	Freedom to choose nationwide. SmartValue is a Private Fee For Service Health Plan. A private fee for service plan allows you to receive health care services from any licensed doctor you choose. As long as your doctor participates in Original Medicare and is willing to accept the terms and conditions of SmartValue, the choice is yours.	Full coverage that can begin as soon as your effective date with no pre-existing condition limitations.	$15 copayment for eye care. $0 copayment for glaucoma screening. $0 copayment for glasses/contacts following cataract surgery. $15 copayment for routine vision exams. **Discount Vision Care** Enjoy up to a 30% savings on a complete pair of prescription glasses, most sunglasses and lens options at thousands of providers nationwide. SmartValue members can choose from private practitioners or leading optical retailers such as LensCrafters, Target Optical, JC Penney Optical and most Pearle vision locations.	Services that are not covered under Original Medicare, unless such services are specifically listed as covered in the Benefits Summary. Experimental or investigational medical and surgical procedures, equipment and medications unless covered by Original Medicare or unless, for certain services, the procedures are covered under an approved clinical trial. A list of exclusions is available in the pre-enrollment booklet and the Explanation of Coverage booklet.
oth brand and generic ceive up to a 30 day certain accessories and ay be filled at any te-Aid pharmacy. t at Kaiser Permanente; d at Kaiser Permanente; t at Kaiser Permanente; d at Kaiser Permanente; d upon a 30 day supply including Norplant and able generic or brand by the number of ive not to exceed $200.	You are covered for emergency and urgent care services anywhere you travel around the world. Emergency care for illness or injury is covered 24 hours a day. If you have an emergency, call 911 or go to the nearest hospital. There is a $50 copayment per emergency room visit. If admitted into the hospital, the emergency care copayment is waived and the inpatient hospital copayment of $200 applies. A $100 copayment applies per ambulance trip. If urgent care services are required, a $20 copayment applies. If seeking services in one of the Kaiser Permanente regions outside of Georgia, you will have a 90 day visiting member benefit for services. Bills for services received outside of the service area must be submitted to Kaiser Permanente for payment within 90 days.	Full coverage is provided for pre-existing conditions.	Vision coverage is available to you through your medical coverage at no additional charge. When obtained from participating eye care providers, eye examinations for disease and corrective lenses are covered at 100% after a $30 copayment. $100 credit for frames and corrective lenses or contact lenses is available once every two years. Visit kp.org/medicalstaff for a vision provider listing, including a list of providers and counties served. You can also have a provider directory mailed to your home by contacting customer service at (404) 233-3700 or (800) 232-4404.	Services and supplies not provided, arranged, or authorized by a Kaiser Permanente physician are not covered except for out-of-plan emergency care. Long-term physical rehabilitation services, extraction of wisdom teeth, hearing aids and most disposable supplies are not covered.

Comparison

PLAN	PLAN DESCRIPTION	SERVICE AREA	
BlueChoice Option Point-of-Service (POS)	The point-of-service (POS) plan offers in-network and out-of-network levels of coverage. In-network medical care is provided at a higher level of coverage when medical services are provided by the primary care physician (PCP) from the list of in-network providers. The out-of-network option allows you to see any provider for covered services, but your out-of-pocket costs will be higher than if you received care in-network. Members must choose a primary care physician (PCP) for each family member. The PCP can be a general/family or internal medicine physician, or pediatrician. The PCP will coordinate care for all members when the members receive medical care from in-network providers. Referrals are required from the PCP for treatment by in-network specialists. Members are **not** required to use in-network providers, but can decide to receive treatment from out-of-network providers at any time with no referrals. For out-of-network care, simply call the doctor and make an appointment. Remember: Your out-of-pocket expenses will be higher when you receive care from out-of-network providers. **NOTE: Members can receive in-network care from an OB-Gyn (one annual check-up), Dermatologist, and Ophthalmologist without a referral from the PCP.**	**In-Network** Covers the state of Georgia. **Out-of-Network** Covers the United States and foreign countries. See the BlueChoice POS Provider Directory or website for detailed information.	**In-Networ** Individual = **Coinsuran** Some mini Plan pays 1 **Copaymen** $15 copay PCP. $25 copay $100 copay component **Out-of-Net** Individual = **Coinsuran** Plan pays 7 **Out-of-Poc** Individual = Family = $
Kaiser Permanente – HMO (Pre-65)	A Health Maintenance Organization providing medical services as described. All care must be provided or arranged by your personal Kaiser Permanente physician – a physician located at one of the Kaiser Permanente medical centers or an affiliated private physician's office. If you have an emergency, call 911 or go to the nearest emergency room. No plan limit or maximum benefit. (Some specific benefits may have limitations.) Please list the chosen PCP's ID number on your application.	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dalton, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding and Walton Counties.	$10 copay visits. Well per visit th copayment Maternity $20 copay Hours cent mental hea Outpatient Detoxifica services fo allergy ser for infertil

(<u>Please Note:</u> This comparison is only intended as a general description of the plans available through the City of Atlan

n of Health Care Plans (Non-Medicare) – Retirees

DEDUCTIBLES/COPAYMENTS	HOSPITAL SERVICES	EMERGENCY ROOM SERVICE
k Deductible = $0 Family = $0 **ce In-Network** mum copayment are required. 00% for most services **ts In-Network** per office visit, physical examination or well child visit from per OB-Gyn examination and specialty physician visit for outpatient surgery outside a physician's office (facility only) **twork Deductible** = $ 300 Family = $ 900 **ce Out-of-Network** 0% after the deductibles are satisfied by the members. **cket Maximum** = $2,000 per calendar year 6,000 per calendar year	**In-Network** Plan pays 100% after a $200 copay per inpatient admission. **Out-of-Network** Plan pays 70% after deductible	**In-Network** = $75 copayment, waived if admitted **Out-of-Network** = $75 copayment, waived if admitted Non-emergency use of the emergency room is not covered. This applies to medical care received in-network and out-of-network.
ment per primary; $30 copayment for specialty care office l-child care covered in full up to age 24 months: then $10 ereafter. $10 copayment for routine check-ups; $30 for Pap smear, prostate checks, and follow-up visits. care and one postnatal visit covered in full. ment for after-hours care at a Kaiser Permanente After er or an Affiliated Community After Hours Center. Inpatient lth care services are covered after a $200 copayment. mental health visits: $30 copayment per visit. tion for alcohol and drug abuse available; contact customer r details. $50 copayment every six months for maintenance um. $10 copayment for allergy injections. 50% of charges ity treatment and prescriptions.	Semi-private or private room if medically necessary after $200 copayment. ICU, CCU and miscellaneous hospital charges covered in full at participating hospitals after applicable copayment. Hospital stay must be authorized by a physician. See physician directory for hospital listing. Inpatient surgery covered at 100% after $200 copayment when authorized. $100 copayment for outpatient surgery.	Emergency care for illness or injury is covered 24 hours a day. (If you have an emergency call 911 or go to the nearest emergency room.) $100 copayment per emergency room visit. Emergency care copayment waived if admitted. $100 copayment per trip for ambulance services.

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s 09/01/2009 - 08/31/2010

PRESCRIPTION DRUGS	CARE OUTSIDE SERVICE AREA	PRE-EXISTING CONDITIONS	VISION CARE	MAJOR EXCLUSIONS
In-Network - Retail - Generic - $10 Brand Formulary - $25| Brand Non-Formulary - $40 - Mail order - Generic- $20 Brand Formulary - $50 Brand Non-Formulary - $80 **Out-of-Network** plan pays 70% after deductible	Only out-of-network benefits are available, subject to calendar year deductible, payable at 70% UCR.	Full coverage is provided for pre-existing conditions	**In-Network** Coverage is available for eye illness or injury only when coordinated through your primary (PCP) or network ophthalmologist. **Out-of-Network** Coverage is available for eye illness or injury by any out-of-network ophthalmologist. **Discount Vision Care** A discount is available when care is received from participating Lenscrafters for eye exams, frames, lenses or contact lenses. You must show your medical ID card.	A list of exclusions is available by consulting your benefits staff, BCBS Ga Members Services or the Summary Plan Description when it is available. This includes medical care which is non-covered, not medically necessary, or experimental or investigational in nature.
Up to a 30 day supply of medication and certain accessories and supplies: $10 copayment generic/$30 copay brand at Kaiser Permanente Pharmacies. $16 copay generic/$36 copayment brand at Rite Aid or Walgreens. Time released drugs, including Norplant and Depo-Provera: $10 copayment generic/$30 copayment brand at Kaiser Permanente Pharmacies. $16 copayment generic/$36 copayment brand at Rite Aid or Walgreens multiplied by the number of months the drug is effective not to exceed $200.	Emergency care is covered after $100 copayment. Emergency care copayment if admitted. Bills for services received outside service area must be submitted to Kaiser Permanente for payment within 90 days. Visiting member benefits available for 90 days in other Kaiser Permanente regions.	Full coverage is provided for pre-existing conditions	When obtained from participating eye care providers, eye examinations for corrective lenses are covered. $30 copayment. You receive a 25% discount off of eyeglasses, a 15% discount off of regular contact lenses, and a 5% discount off of disposable contact lenses.	Services and supplies not provided, arranged, or authorized by a Kaiser Permanente physician, except for out-of-plan emergency care. Long-term physical rehabilitation services, extraction of wisdom teeth, hearing aids and most disposable supplies are not covered.

KAISER PERMANENTE SENIOR ADVANTAGE HMO USER GUIDE (MEDICARE ELIGIBLE) 09/01/2009 - 08/31/2010

When joining Kaiser Permanente Senior Advantage, you must complete a separate application. When/if you terminate your Kaiser Senior Advantage, you must complete a Medicare disenrollment form.

Complete. Simple. Affordable. Now That's a Senior Advantage.

Complete.

You'll have peace of mind knowing you're covered for:

- *Medical* – Includes doctor visits, vision services, physical exams, screenings and more.
- *Hospital* – An unlimited number of days each hospital stay costs you only $200.
- *Prescriptions* – Coverage for all brand and generic drugs listed on our formulary.

Simple.

You'll enjoy a plan that's simple to understand and simple to use.

- One low monthly premium pays for all your coverage.
- No claims to file.

And so much more!

When you join Kaiser Permanente Senior Advantage, you'll get high quality, personalized care from our award-winning medical group. You'll also love the timesaving convenience of our medical centers. And, you'll have the tools you need to help keep you health – like access to 24-hour health coaches or nurse advice, discounts on health-related services, online self-help tools, health classes and more.

How do I choose or change my primary care physician?

We ask you to choose a personal physician upon enrollment so that you and your doctor can develop a partnership and work together to make sure you get the quality care you deserve. Your personal physician will guide and coordinate any care you receive in the hospital or from specialists. And having one doctor who arranges your care and knows your medical history helps you get the right care from the right people. The relationship you build with your personal physician can help you achieve and maintain both good health and good spirits.

You may choose a physician in family medicine, general practice, adult medicine or pediatrics/adolescent medicine as a personal physician. (Refer to the *Kaiser Permanente Senior Advantage HMO Physician Directory* in your enrollment packet for specifics or kp.org.)

Simply call our Customer Service Department at **(404) 261-2590** locally or **(888) 865-5813** long distance.

How do I make an appointment?

It's really easy. There is one number to call to make or cancel appointments, speak with an advice nurse, or access after-hours urgent care – regardless of which Kaiser Permanente Medical Center you use. Call the Health Line at **(404) 261-2590** locally or **(888) 865-5813** long distance. **(TTY: 800-255-0056)**.

If your personal physician is one of our Affiliated Community Physicians, call his or her office directly to make an appointment.

To schedule or cancel appointments, you may call Monday through Friday from 7 a.m. to 7 p.m. The Health Line is open to speak with an advice nurse 24 hours a day, seven days a week.

What if I need to see a specialist?

When you select a personal physician, keep in mind that your choice will determine which specialists are available to you. Your personal physician has an established relationship with a specific group of specialty care doctors with whom he or she works with on a regular basis. By referring only to a certain group of specialists, your physician is better able to coordinate

and oversee your care. You must get a referral from your personal physician in order to see a specialist. If you change your personal physician, the specialists available to you may also change.

Referral specialists are listed in your Kaiser Permanente Senior Advantage HMO Physician Directory.

As a Kaiser Permanente member, you have direct access to OB/GYNS, Dermatologists, Ophthalmologists, Optometrists, Psychiatrists and Behavioral Specialists. No referral is required.

What if I need to be admitted to the hospital?

Kaiser Permanente is affiliated with some of Atlanta's most prestigious hospitals. The personal physician you choose will determine the hospital to which you will be admitted. The hospitals used for most inpatient care are: Children's Healthcare of Atlanta at Scottish Rite, Emory Eastside Medical Center, Northside Hospital and Piedmont Hospital.

Get Connected

With Kaiser Permanente, you have secure, 24-hour access to portions of your health record online at kp.org. You also have increased access to your doctor and more tools to help you take a more active role in your health.

With these new time-saving features, you can:

- E-mail your doctor's office
- View certain lab test results
- Review past office visit information and future appointments
- Monitor your ongoing health conditions
- Access the health records of your children
- View your allergies

What should I do if I need emergency care?

If you have an emergency, call 911 or go to the nearest emergency room.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

If you are hospitalized, you should call (or have someone else call) the Kaiser Permanente Health Line – **(404) 261-2590** locally or **(888) 865-5813** long distance – to notify us of your hospital admission as soon as you can within 24 hours of your admission. **(TTY: 800-255-0056)**. This will allow us to consult with the physician providing your care and to coordinate further medical care.

You will pay a $50 copayment for emergency room services. (Emergency fees are waived if you're admitted.) Students attending school outside of the Kaiser Permanente service area will be covered for up to $500 for follow-up care associated with emergency services.

Do I fill out claim forms?

There are no claim forms required if care is provided, prescribed, or directed by a Kaiser Permanente physician. If there is a copayment, coinsurance, or deductible, you will be expected to pay at the time you receive the services.

If you have any questions about claims, please call a Claims Services Representative at **(404) 261-2590**. **(TTY: 800-255-0056)**.

What if I have additional questions?

Call Senior Advantage Customer Services Department from 8:30 a.m. to 5 p.m., Monday through Friday, at **(404) 233-3700** or **(800) 232-4404**, or **(800) 255-0056** (TTY for the hearing and speech impaired). You can also visit our website at www.kp.org.

Note: Retirees and/or their spouses covered by Parts A & B of Medicare who enroll with Kaiser Permanente are only eligible for Senior Advantage. Other family members may enroll in the HMO plan.

KAISER PERMANENTE SENIOR ADVANTAGE HMO USER GUIDE (MEDICARE ELIGIBLE) 09/01/2009 - 08/31/2010 *(cont'd)*

CATEGORY	09/01/2009 - 08/31/2010 – HMO PLAN DESIGN
Deductible	Not applicable
Office Visits	$10 co-pay
Specialist	$30 co-pay
Out-patient Surgery; facility; visits	$100 co-pay
Maternity Out-patient	$30 co-pay 1st visit; then 100% thereafter
Pediatric Office Visit	$10 co-pay
Immunizations	$10 co-pay, (well child care covered @100% up to age 2)
Prescription Brand	$30 co-pay at Kaiser per 30 day supply; $36 co-pay at Rite-Aid
Prescription Generic	$10 co-pay at Kaiser per 30 day supply; $16 co-pay at Rite-Aid
Mail Order	Up to 90 days supply @ 3 times Kaiser RX co-pay
Inpatient Hospital Care	$200 co-pay per admission
Maternity In-patient	100% covered after $200 co-pay
Mental Health: Out-patient	$30 co-pay for unlimited visits
Ambulance	$100 co-pay
Emergency Room: In Plan	$50 co-pay
Emergency Room Out Plan	$50 co-pay
Urgent Care	$20 co-pay
Mental Health In-patient	$200 co-pay per admission
Substance Abuse: Out-patient	$30 co-pay; unlimited visits per calendar year.
Substance Abuse: In-patient	$200 per admission
X-Rays & Lab work	100% covered
Vision Eye Exam	$30 co-pay
Frames/Contact Lenses	$100 credit vision hardware
Infertility	$30 co-pay for diagnosis; 50% for treatment.
Physical/Occupational Therapy (combined benefit)	$30 co-pay; unlimited visits
Speech Therapy	$30 co-pay; unlimited visits
DME Equipment	80% covered

KAISER PERMANENTE SENIOR ADVANTAGE HMO USER GUIDE (MEDICARE ELIGIBLE) 09/01/2009 - 08/31/2010 *(cont'd)*

For the plan year beginning on September 01, 2009 and ending on August 31, 2010.

CITY OF ATLANTA – SENIOR ADVANTAGE

Additional Information

- This benefit chart is a summary of the most frequently asked about benefits and their copayments. This is not a contract. Specific benefits, exclusions, and limitations are contained in the Group Agreement we have with your employer and the Evidence of Coverage you will receive. In the case of a conflict between this benefit chart and the Evidence of Coverage, the Evidence of Coverage will prevail. For specific questions about coverage, please ask your employer's benefits office or contact Kaiser Permanente Customer Services at **(404) 261-2590**. Benefits are subject to approval by the Georgia Department of Insurance.

- The following is a partial list of exclusions and limitations under this plan: Services that are not medically necessary; Certain exams and other services required for obtaining or maintaining employment or participation in employee/retiree programs, or required for insurance or licensing, or on court order or for parole or probation; Cosmetic services; Custodial or intermediate care; Services that an employer is required by law to provide; Experimental or investigational services; Eye surgery, including laser surgery, to correct refractive defects; Services that a government agency is required by law to provide; Services for conditions arising from military service; Services related to the treatment of morbid obesity (except certain health education programs are covered); Routine foot care; Sexual reassignment services; Non-human or artificial organs or their implantation; Reversal of voluntary infertility; Transportation and lodging expenses; Conditions covered by workers' compensation or under employer liability law; Services not generally and customarily available in our service area.

- In order for Services to be covered, a Plan Physician must determine that the Services are medically necessary to prevent, diagnose, or treat your medical condition. With the exception of emergency services, all covered Services must be provided, prescribed, authorized, or directed by a Plan Physician. You must receive the Services at a Plan Facility inside our Service Area, except where specifically noted to the contrary in the Evidence of Coverage. Certain covered services require pre-authorization by Medical Group.

- We use a formulary, which is a listing of medications that our physicians and pharmacists consider to be the most safe, useful and cost-effective ones available. A team of Kaiser Permanente physicians and pharmacists independently and objectively evaluates the scientific literature to identify the FDA-approved drugs best suited to treat specific medical conditions. Coverage for prescription drugs is limited to those drugs that are included on the Kaiser Permanente formulary. For a copy of the formulary brochure or for more information about the exception process, contact Customer Services at **(404) 261-2590**.

- For details on the benefit and claims review and adjudication procedures, please refer to your Evidence of Coverage.

- Kaiser Permanente maintains policies regarding the confidentiality, protection, and disclosure of personal health and member identifiable information, including policies related to access to medical records. If you have questions about our policies and procedures to maintain the confidentiality of personal information or would like a more comprehensive notice describing how Kaiser Permanente collects and uses personal information, please call Customer Services at **(404) 261-2590**.

This plan summary is intended to only highlight some of the principal provisions of the plan. Please refer to the Group Agreement or Evidence of Coverage for further details of the plan or for specific limitations and exclusions.

CIGNA DENTAL PPO PLAN MEMBER GUIDE 09/01/2009 - 08/31/2010

Description of Benefits

The City of Atlanta offers the choice of two CIGNA Dental PPO plans (High Option or Low Option) for you and your eligible dependents. These comprehensive plans are administered by CIGNA Dental.* Most dental services, including preventive care, are covered. The annual dollar maximum for both the High and Low Options is $2,000.

Who Can Provide Services

The CIGNA Dental PPO plan is a preferred provider program. Members can seek care in- or out-of network. Participating CIGNA Dental network dentists have agreed to charge reduced fees for covered services; out-of-network dentists provide services at their usual fees. When you use an out-of-network dentist, you may be billed for the difference between the payment the dentist receives from CIGNA and his/her usual fees.

Proof of Coverage

After enrollment, you will receive a CIGNA Dental PPO ID card. However, the ID card is not required to access care.

Claims

Most network dentists will file claims on your behalf; out-of-network dentists may ask you to file the claim. CIGNA Dental will determine benefits, and payment will be made to the dentist or to you based on what is indicated on the claim form. Generally, you or your dentist should receive reimbursement in about three weeks.

How to Obtain Assistance

Help is only a phone call away! If you have questions about the dental plans, want to know the status of a claim, or need to know if specific services are covered, you can contact CIGNA Dental Member Service toll-free at **1-800-CIGNA24 (1-800-244-6224)**. You can also access personalized dental plan information when you register at ***www.myCIGNA.com***. Through myCIGNA.com, you can:

- Review your dental benefit plan information, including individual and family maximums and deductibles
- Find network dentists through the on-line provider directory
- Check on the status of a claim
- Access dental health news and information from trusted sources
- Print Dental ID cards

How to Appeal Claims

If you disagree with the processing of your claim, you have the right to ask for a review of the claim. Please refer to the "Right to Appeal" section of your benefit booklet for details.

Orthodontics in Progress

"Orthodontics in progress" refers to orthodontic care in progress at the time your dental coverage becomes effective. If your dependent is in the midst of orthodontic treatment when you join the plan, you may be eligible for some contribution.

Your CIGNA Dental PPO plan provides an orthodontic benefit; it covers orthodontics in progress, subject to your plan limitations. The orthodontics in progress benefit is calculated based on the coinsurance level for orthodontic treatment and the number of months of treatment remaining after your effective date. Benefit amounts are payable up to the lifetime dollar maximums or until the treatment is completed, which ever comes first.

Your CIGNA Dental PPO plan also covers orthodontics for new members who are in treatment prior to enrollment. Treatment will become effective the date the retiree becomes effective. The original treatment must be submitted by the provider, which should include the total months of treatment, total fee (including retention) and the banding date. The contracted rate will be paid for the remaining months of treatment until the lifetime maximum has been met or until the treatment is completed, whichever comes first.

The patient balance due on the EOB will be incorrect because CIGNA will only be responsible to pay up to the PPO contracted amount for the remaining months of treatment. However, the patient will be liable for the provider's original case fee because that was the original financial agreement between the patient and provider.

** CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.*

CIGNA DENTAL PPO PLAN MEMBER GUIDE 09/01/2009 - 08/31/2010 *(cont'd)*

CIGNA Dental PPO Benefit Summary Effective 09/01/2009 - 08/31/2010

This is a summary of benefits for your PPO plan. All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in- and out-of-network.

BENEFITS	CIGNA DENTAL HIGH PPO		CIGNA DENTAL LOW PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Maximum (Class I, II, and III Expenses)	$2,000	$2,000	$2,000	$2,000
Calendar Year Deductible Per Individual Per Family	 $50 $150	 $50 $150	 $50 $150	 $50 $150
Class I Expenses – Preventive & Diagnostic Care Oral Exams Cleanings (1 per 6-month consecutive period) Bitewing X-rays Fluoride Application Sealants Space Maintainers *(limited to non-orthodontic treatment)* Full Mouth X-rays Panoramic X-rays	100% No deductible	100% No deductible Subject to reasonable and customary allowances.	100% No deductible	100% No deductible Subject to reasonable and customary allowances.
Class II Expenses - Basic Restorative Care Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Major Periodontics ** Minor Periodontics ** Root Canal/Therapy	80%, After Deductible	80%, After Deductible Subject to reasonable and customary allowances.	80%, After Deductible	80%, After Deductible Subject to reasonable and customary allowances.
Class III Expenses - Major Restorative Care Anesthetics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns and Inlays Repairs - Dentures Crowns Dentures Bridges Histopathologic Exams TMJ coverage (with separate $1000 lifetime max)	50%, After Deductible	50%, After Deductible Subject to reasonable and customary allowances.	50%, After Deductible	50%, After Deductible Subject to reasonable and customary allowances.
Class IV Expenses - Orthodontia Coverage for Eligible Children and Adults Lifetime Maximum	50% No Separate Deductible $1,500	50% No Separate Deductible $1,500	Not Covered	Not Covered
Missing Tooth Provision	Teeth missing prior to coverage under the CIGNA Dental plan are not covered.		Teeth missing prior to coverage under the CIGNA Dental plan are not covered.	
Pretreatment Review	Available on a voluntary basis when extensive work in excess of $500 is proposed.		Available on a voluntary basis when extensive work in excess of $500 is proposed.	
Out-of-Network Reimbursement	80th Percentile of Reasonable and Customary Allowances		80th Percentile of Reasonable and Customary Allowances	
Student Age	26		26	

** CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental PPO is underwritten or administered by Connecticut General Life Insurance Company with network management services provided by CIGNA Dental Health, Inc., and certain of its operating subsidiaries.*

***** Perio coverage has a separate $1,000 lifetime maximum.***

CIGNA DENTAL PPO PLAN MEMBER GUIDE 09/01/2009 - 08/31/2010 *(cont'd)*

CIGNA Dental PPO/Indemnity Exclusions and Limitations

Procedure	Exclusions & Limitations
Late Entrants Limit	No coverage except for Class I (as defined in these plans) for 12 months.
Exams	1 per 6-month consecutive period.
Prophylaxis (Cleanings)	1 routine prophy or perio maintenance procedure per 6-month consecutive period (routine prophy is Class I; perio prophy is Class II).
Fluoride Treatments	1 per consecutive 12 months for participants younger than age 14.
Histopathologic Exams	Payable if the biopsy is covered. No coverage for other diagnostic tests.
X-rays (routine)	Bitewings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set.
X-rays (non-routine)	Full mouth or Panorex: 1 per 60 consecutive months.
Periapical x-rays	4 in 12 consecutive months if not performed in conjunction with an operative procedure
Intraoral occlusal x-rays	2 in 12 consecutive months
Models	Not covered.
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only).
Sealants	1 treatment per tooth per lifetime for children younger than age 14 only. Payable on unrestored permanent bicuspid or molar teeth only.
Minor Perio (non-surgical)	Root planing – 1 per quadrant per 36 consecutive months.
Perio Surgery	1 per 36 consecutive months per area of the mouth (same service).
Crowns and Inlays	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges. Replacement must be indicated by major decay.
Bridges	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Dentures and Partials	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months.
Repairs - Bridges	Covered if more than 12 months after installation.
Repairs - Dentures	Covered if more than 12 months after installation.
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated.

Benefit Exclusions:

- Services performed primarily for cosmetic reasons; Replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;
- Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- Replacement of a bridge, denture or crown which can be made useable according to dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Core buildup, labial veneers; Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- Implants are excluded with the exception of the prosthesis over the implant (Prosthesis being the crown, bridge or denture placed over the implant post.)
- Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type including any prosthetic device attached to it;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards; Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Procedures for which a charge would not have been made in the absence of coverage, for which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments; Procedures which are not necessary and which do not have uniform professional endorsement;
- Any injury resulting from, or in the course of, any employment for wage or profit; Any sickness covered under any workers's compensation or similar law;
- Reasonable and Customary other that the defined percentile;
- IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless Connecticut General agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture; Replacement of teeth beyond the normal complement of 32;
- Prescription drugs; Athletic mouth guards; Myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by CG; Temporary, transitional or interim dental services; Diagnostic casts, diagnostic models, or study models;
- Any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of ($100.00 - $200.00) per 12 consecutive month period);
- Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law; or an uninsured motorist insurance law.

HUMANA (COMPBENEFITS) DENTAL ACCESS PLAN 09/01/2009 - 08/31/2010

Welcome to *Dental Access*

Humana (CompBenefits) is pleased to offer you and your family an innovative option in dental benefits called *Dental Access*. Preventive dental care is an important part of everyone's health care needs. *Dental Access* is designed to meet your needs by providing affordable coverage and reducing the cost associated with maintaining good dental health.

DENTAL ACCESS OFFERS:

Access

- Freedom to use any dentist with benefit incentives to use participating network providers
- Freedom for each family member to have their own dentist
- Immediate access to Specialists at fixed copayments
- No referral required for specialty care

Savings

- No deductibles
- Fixed member in-network copayments with no balance billing
- Scheduled reimbursement for out-of-network dental services
- No benefit waiting periods

Convenience

- No claims forms for in-network services
- No pre-authorization needed to change dentist or to use non-participating providers

Dental Access provides the protection, flexibility and the coverage you and your family desire. The plan offers both in-network and out-of-network benefits, that gives you and your family the ability to receive care from any dentist in the community. While most of the time there will be higher out-of-pocket costs for care obtained out-of-network, the plan provides you the comfort of having this flexibility.

IN-NETWORK COVERAGE

Private practice dentists who contract with Humana (CompBenefits) provide treatment and services for you and your family. These dentists agree to provide the comprehensive benefits outlined in your dental plan and to accept the Humana (CompBenefits) fee schedule. Upon enrolling in the plan, you may seek treatment from any dentist listed in the network directory. Your dentist will charge specific copayments for covered procedures. This means fewer out-of-pocket expenses for you when using your in-network coverage. See the Schedule of Benefits for exact copayments and reimbursements per dental procedure.

THE IN-NETWORK ADVANTAGE

- Preventive and diagnostic services covered at 100 percent, including routine cleanings, examinations, X-rays, fluoride treatments and emergency palliative treatment (Office visit copayment may apply)
- Coverage for restorative and specialty care with fixed copayments
- Flexibility to choose any network dentist at any time
- Family Choice, which allows each family member to select a different general care dentist
- Immediate specialty access
- Quality assessment of participating dental offices

Humana (CompBenefits) is very concerned with providing you and your family with access to quality care and therefore takes the appropriate measures to verify the professional credentials of dentists applying for participation in the Humana (CompBenefits) network. On-site quality assurance inspections are performed on participating dental offices on an annual basis.

OUT-OF-NETWORK COVERAGE

If you should decide to seek services outside of Humana (CompBenefits)' network of participating dental providers, you would simply receive dental care from any licensed, practicing dentist. You would pay for the treatment rendered, complete a claim form, and submit the form to Humana (CompBenefits) for direct reimbursement to you of approved claims. There are no deductibles or waiting periods to receive coverage. Refer to Benefits, Limitations and Exclusions for a detailed review of benefits. **A fixed dollar amount is reimbursed on each procedure. The applicable Preventive & Diagnostic Office Visit Copayment is deducted from the maximum reimbursement amount for preventive and diagnostic procedures.**

Your responsibility under this option includes any cost that remains after the insurance reimbursement and maximum benefit limitations. Your plan also covers a portion of the cost associated with emergency dental care that you may receive from a non-participating provider.

HUMANA (COMPBENEFITS) DENTAL ACCESS PLAN 09/01/2009 - 08/31/2010 *(cont'd)*

BENEFIT SUMMARY

Below is a brief summary of the dental benefits under the *DENTAL ACCESS* plan. This is provided as an overview document. Details about your coverage are outlined in your Schedule of Dental Benefits. Should there be any difference between this summary and the Benefits Schedule, the terms and conditions of the Benefits Schedule will prevail.

DENTAL ACCESS

	In-Network	Out-of-Network
Benefit Level	See Benefit Schedule	Schedule Reimbursements
Preventative & Diagnostic Office Visit Co-pay	None	None
Annual Deductible	$0.00	$0.00
Annual Benefit Maximum	Unlimited	Unlimited

BENEFIT SUMMARY FOR COVERED DENTAL SERVICES

	You Pay Humana (CompBenefits) Provider	Humana (CompBenefits) Reimburses You
PREVENTIVE & DIAGNOSTIC SERVICES		
Periodic Oral Examination*	No charge	$24.00
Bitewing X-rays – Four*	No charge	$27.00
Panoramic Film*	No charge	$50.00
Prophylaxis – Adult*	No charge	$45.00
Prophylaxis – Child*	No charge	$30.00
Fluoride – Child (including prophylaxis)*	No charge	$35.00
Sealants (permanent molars only)*	No charge	$23.00
BASIC SERVICES		
Amalgam Filling – Two Surface	$0.00	$52.00
Composite Filling – Two Surface Anterior	$0.00	$52.00
Prefabricated Steel Crown – Primary	$90.00	$19.00
Pulp Cap – Direct (excluding final restorations)	$0.00	$23.00
Root Canal – Bicuspid	$0.00	$289.00
Scaling and Root Planning – Per Quad (4+ teeth per quad)*	$0.00	$79.00
MAJOR SERVICES		
Crown-Porcelain Fused To Noble Metal	$354.00	$136.00
Complete Full Upper Dentures*	$472.00	$132.00

ORTHODONTIC COVERAGE

Children Coverage	$3,035 maximum fee	$365.00
Adult Coverage	$3,325 maximum fee	$165.00

Services indicated with an asterisk (*) are subject to frequency and/or age limitations. Consult your Benefits Schedule for a complete list of these frequencies, limitations and exclusions that apply.

This material is a brief outline of benefits and covered services. The full Schedule of Benefits with a complete explanation of services, exclusions, and limitations will be included in your enrollment book.

HUMANA (COMPBENEFITS) DHMO DENTAL PROGRAM 09/01/2009 - 08/31/2010

Welcome to the Humana (CompBenefits) DHMO Dental Program

Regular professional dental care is important to maintaining healthy teeth and gums. With rising dental fees, it can also be quite expensive.

Your selection of the **DHMO** Dental Program will provide professional dental care while helping you control dental expenses.

If you enroll in dental coverage, you must remain in the program selected for a period of 12 months.

With the **DHMO** program, you have coverage for preventive, basic and major services, and you can take advantage of:

- **Lowest payroll deduction option!**
- **No deductibles**
- **No annual maximum**
- **Generally lower out-of-pocket expenses than a traditional program.**

  (See your Schedule of benefit copayments for more details.)

CHOICE OF DENTISTS

Humana (CompBenefits) contracts with dentists in the community to provide quality care to our members. To receive benefits, you and each of your dependents must select a dental facility from the Humana (CompBenefits) list of participating dental offices. Dentists undergo a thorough review process prior to participation in the network. A licensed general dentist and staff of professional auxiliaries operate each office. If you wish, you may select a different dentist for each covered dependent so that each covered dependent can receive dental care where it is most convenient.

MAKING AN APPOINTMENT WITH YOUR DENTIST

You may schedule appointments by calling the dental office you selected after your effective date of coverage. When you call to schedule your appointment, notify the office that you are a member of the Humana (CompBenefits) dental plan. Call **(800) 342-5209** if you are not certain about your dental provider selection.

CHANGING YOUR SELECTION OF DENTIST

Members may wish to transfer to another participating dental office or provider. Transfer requests may be made in writing to Humana (CompBenefits) or may be requested by calling Humana (CompBenefits') Member Support Department at **(800) 342-5209**. Outstanding balance must be cleared before a transfer request will be honored. Requests received by Humana (CompBenefits) during the first 15 days of the month will become effective the first of the following subsequent month. Members may not be seen at 2 different participating dental offices during the same one-month period. Humana (CompBenefits) may open and close enrollment at any participating dental offices and providers from time to time.

SPECIALIST CARE

Certain dental procedures require the services of a specialist (i.e. some oral surgery, endodontics, periodontics and pedodontics). In those cases, you must seek treatment from Humana (CompBenefits) specialty providers to receive appropriate discounted fees. A referral is needed from your general dentist in order to receive services from a specialist in the DHMO network. Access to orthodontic discounts does not require a referral!

OPTUMHEALTH VISION BENEFITS SUMMARY 09/01/2009 - 08/31/2010

CITY OF ATLANTA – Program Year Effective 09/01/2009 - 08/31/2010 – Underwritten by United HealthCare Insurance Company

BENEFITS AT A OPTUMHEALTH VISION NETWORK PROVIDER	
COMPREHENSIVE VISION EXAM ($15 copay; Once Every 12 Months)	A vision examination is provided by a network optometrist or ophthalmologist, after applicable copay.
MATERIALS ($25 copay)	The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.
PAIR OF LENSES (for eyeglasses) (Once Every 12 Months) • Standard single vision • Standard lined bifocal • Standard lined trifocal • Standard lenticular	**Standard scratch-resistant coating, tints and UV are covered-in-full.** **Lens Options** – Options such as progressive lenses, polycarbonate lenses and anti-reflective coating may be available at a discount.
FRAMES (Once Every 12 Months)	Receive a $50 wholesale frame allowance (approximate retail value of $120 to $150) at private practice providers, or a minimum $130 frame allowance at retail chain providers.
CONTACT LENSES (in lieu of eyeglasses) (Once Every 12 Months)	
• Covered-in-full elective contact lenses	The fitting/evaluation fees, contacts (including disposables), and up to two follow-up visits are covered-in-full (after applicable copay) for many popular brands, such as Acuvue by Johnson & Johnson and Optima by Bausch & Lomb. If covered disposable contact lenses are chosen, up to 6 boxes (depending on prescription) are included when obtained from a network provider. It is important to note that OptumHealth Vision's covered-in-full contact lenses may vary by provider.
• All other elective contacts	A $150 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside of OptumHealth Vision's covered-in-full contacts (materials copay does not apply). Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.
• Necessary contact lenses*	Covered-in-full (after applicable copay).
REFRACTIVE EYE SURGERY	OptumHealth Vision participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States. To find a participating laser eye surgeon in your area, visit our Web site at www.myoptumhealth.com.

BENEFITS AT AN OUT-OF-NETWORK PROVIDER

SERVICE	AMOUNT
Exam	
Optometrist	up to $40
ophthalmologist	up to $40
Lenses	
Single Vision	up to $40
Bifocal	up to $60
Trifocal	up to $80
Lenticular	up to $80
Frames	up to $45
Contact Lenses (in lieu of eyeglasses)	
Elective	up to $150
Necessary*	up to $210

If you choose an out-of-network provider, you will need to send your itemized receipts, with the primary-insured's unique identification number and the patient's name and date of birth, to:

OptumHealth Vision
P. O. Box 30978
Salt Lake City, UT 84130

Please note: Receipts for services and materials purchased on different dates must be submitted together at the same time to receive reimbursement.

** Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery; To correct extreme vision problems that cannot be corrected with spectacle lenses; With certain conditions of anisometropia; With certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask your provider to contact OptumHealth Vision concerning the reimbursement that OptumHealth Vision will make before you purchase such contacts.*

OPTUMHEALTH VISION BENEFITS SUMMARY 09/01/2009 - 08/31/2010 *(cont'd)*

Important to Remember:

- Always identify yourself as a OptumHealth Vision participant when making your appointment. This will assist your provider in obtaining a claim authorization number prior to your visit.
- Benefits available every 12 months, based on last date of service.
- Your $150 contact lens allowance is applied to the fitting/evaluation fees as well as the purchase of contact lenses. For example, if the fitting/evaluation fee is $30, you will have $120 towards the purchase of contact lenses. The allowance may be separated at some retail chain locations between the examining physician and the optical store. Toric, gas permeable, and bifocal contacts are all examples of contacts that are outside of our covered-in-full selection.

The following Services and Materials are excluded from coverage under the Policy:

1. Post cataract lenses
2. Non-prescription items
3. Medical or surgical treatment for eye disease, that requires the services of a physician
4. Worker's Compensation services or materials
5. Services or materials that the patient, without cost, obtains from any governmental organization or program
6. Services or materials that are not specifically covered by the Policy
7. Sunglasses, plain or prescription
8. Replacement or repair of lenses and/or frames that have been lost or broken
9. Cosmetic extras, except as stated in the Policy's Table of Benefits.

Provider Locator

With OptumHealth Vision you are able to choose from network private practice providers and retail chain providers. Prior to enrolling in or using the OptumHealth Vision vision program, if you would like to identify a network provider, visit OptumHealth Vision's Website – www.myoptumhealth.com and provide locator or call OptumHealth Vision's Provider Locator Service at **1-800-839-3242** and follow the voice prompts:

- Enter the primary insured's unique identification number.
- Enter the ZIP code for the area you wish to check.
- After each entry, the system will repeat what you have entered and ask that you "Press 1" if correct, or "Press 2" if incorrect.
- The system will then identify up to three network providers in the requested ZIP code area.
- If you wish to hear the selections again, "Press 1". To enter another five-digit ZIP code, "Press 2".

Prior to using your benefits at a network provider, please call the provider and make an appointment. Please inform the provider that you are a OptumHealth Vision participant.

*PLEASE NOTE: If there are differences in this document and the Group Policy, the Group Policy is the governing document. Please retain this Benefit Summary and Vision Care Program description that includes detailed benefit information and instructions on how to use the program. Customer Service is available toll-free at **1-800-638-3120** from 8:00 am to 11:00 pm, Monday thru Friday, and from 9:00 am to 6:30 pm on Saturdays.*

ID cards will be issued to all enrollees.

RETIREE COST OF HEALTH COVERAGE 09/01/2009 - 08/31/2010

Retiree Cost of Health Care Coverage

You and the City of Atlanta share the cost of your health insurance coverage. The cost of the coverage varies from year to year.

Your costs for health coverage from 09/01/2009 - 08/31/2010 are as follows:

OPTIONAL NON-MEDICARE HEALTH PLANS

	BLUE CROSS/BLUE SHIELD POS		KAISER PERMANENTE HMO	
	Retiree Cost	*City Cost*	*Retiree Cost*	*City Cost*
Monthly Rates - WITHOUT MEDICARE				
Retiree Only	$132.86	$310.02	$112.35	$262.16
Retiree & Child(ren)	$232.51	$542.52	$196.61	$458.77
Retiree & Spouse/Domestic Partner	$332.16	$775.03	$280.89	$655.41
Retiree & Family	$438.72	$1,023.22	$370.77	$865.13
Beneficiary Child(ren)	$99.65	$232.51	$112.35	$262.16
Widow(er)	$170.02	$396.72	$112.35	$262.16
Widow(er) and Child(ren)	$269.66	$629.22	$196.61	$458.77

OPTIONAL MEDICARE ADVANTAGE HEALTH PLANS*

	BLUE CROSS/BLUE SHIELD SMARTVALUE		KAISER SENIOR ADVANTAGE	
	Retiree Cost	*City Cost*	*Retiree Cost*	*City Cost*
Monthly Rates - WITH MEDICARE ADVANTAGE - Retiree & Spouse/Domestic Partner enrolled in Medicare Parts A and B. Remember to attach a copy of your Medicare card to your application.				
Retiree Only – Medicare Advantage	$83.57	$195.01	$93.98	$219.29
Retiree &Child (ren) – one Medicare Advantage	$183.22	$427.51	$248.46	$579.75
Retiree & Spouse/Domestic Partner – one Medicare Advantage	$282.87	$660.02	$206.33	$481.44
Retiree &Spouse/Domestic Partner – two Medicare Advantage	$167.15	$390.01	$187.96	$438.58
Retiree & Family – one Medicare Advantage	$389.23	$908.21	$335.54	$782.93
Retiree & Family – two Medicare Advantage	$266.79	$622.52	$300.31	$700.73
Beneficiary Child(ren) – Medicare Advantage	$83.57	$195.01	$93.98	$219.29
Widow(er) – Medicare Advantage	$83.57	$195.01	$93.98	$219.29
Widow(er) and Child(ren) – one Medicare Advantage	$183.22	$427.51	$248.46	$579.75

NOTE: Retirees and/or spouses/dependents that are Medicare eligible must obtain coverage under both Parts A and B of Medicare and must enroll in the BCBS SmartValue plan or the Kaiser Senior Advantage plan. Medicare eligible retirees waiting to obtain Part B may enroll in the non-Medicare HMO or POS options but will be asked to provide proof of application for Part B during the first quarter of 2010.

* These rates are applicable to employees who retire on or before 8/31/09 and are Medicare eligible

RETIREE COST OF OPTIONAL DENTAL & VISION COVERAGE 09/01/2009 - 08/31/2010

Retiree Cost of Optional Dental Coverage

You and the City of Atlanta share the cost of your optional dental insurance coverage. The cost of the coverage varies from year to year.

Your costs for dental coverage from 09/01/2009 - 08/31/2010 are as follows:

OPTIONAL DENTAL PLANS

	CIGNA DENTAL PPO PLANS				HUMANA (COMPBENEFITS) CORPORATION			
	High Option (Orthodontics)		Low Option (No Orthodontics)		Access Plan (Orthodontics)		Pre-Select Plan (No Orthodontics)	
	Retiree Cost	*City Cost*	*Retiree Cost*	*City Cost*	*Retiree Cost*	*City Cost*	*Retiree Cost*	*City Cost*
Monthly Rates								
Retiree Only	$7.89	$18.41	$7.89	$18.40	$4.54	$10.58	$3.06	$7.14
Retiree & Child(ren)	$16.74	$39.07	$15.30	$35.70	$8.81	$20.55	$5.56	$12.98
Retiree & Spouse/Domestic Partner	$16.09	$37.55	$16.09	$37.55	$9.25	$21.59	$6.09	$14.20
Retiree & Family	$26.48	$61.80	$24.29	$56.69	$13.99	$32.66	$9.43	$22.00
Beneficiary Child(ren)	$16.74	$39.07	$15.30	$35.70	$9.25	$21.59	$5.56	$12.98
Widow(er)	$7.89	$18.41	$7.89	$18.40	$4.84	$10.28	$3.36	$7.14
Widow(er) and Beneficiary Child(ren)	$16.74	$39.07	$15.30	$35.70	$9.25	$21.59	$5.56	$12.98

Retiree Cost of Optional Vision Coverage

You must pay the entire cost of your optional vision insurance coverage. The cost of the coverage varies from year to year.

Your costs for vision coverage from 09/01/2009 - 08/31/2010 are as follows:

OPTIONAL VISION PLAN

	OPTUMHEALTH VISION
	Retiree Cost
Monthly Rates	
Retiree Only	$4.80
Retiree & Child(ren)	$10.56
Retiree & Spouse/Domestic Partner	$10.06
Retiree & Family	$13.59
Widow(er)	$5.76
Beneficiary Child(ren)	$4.80
Widow(er) and Beneficiary Child(ren)	$10.56

RETIREE LIFE INSURANCE
09/01/2009 - 08/31/2010

You make a great investment in your family. You spend time with them. You care for them, and if you're not there for them, you want them protected. As a City of Atlanta retiree receiving a pension benefit, you are eligible for life insurance coverage.

Following is an outline of the Life Insurance benefits that are available. This information is provided as an overview and does not constitute a contract. Please refer to the Life Insurance policy for detailed explanation of policy provisions.

Eligibility

To be eligible for this plan:

- You must be a retiree of The City of Atlanta or you must be a widow(er) of an employee or retiree covered by insurance at the time of your spouse's death.
- You must have had life insurance coverage as an active employee at the time of retirement.
- For Dependent Life insurance your spouse or children must not be full-time members of the armed forces of any country.
- Widow(er) can not cover dependents.

Retiree/Widow(er) Coverage

- $5,000
- Some grandfathered employees may have different amounts.
- A retiree or widow(er) who terminates his/her coverage is not eligible to return to the City Plan in the future.

Spouse and Dependents Coverage

- Dependents Life Insurance is also available and would provide the following coverage:

  Spouse: $5,000

  Child between birth and six months: $600

  Child between six months and 19 years (26 if a full time student): $5,000
- All late applications will require medical underwriting approval by Greater Georgia Life.
- A Surviving Spouse who is insured at the time an Employee or retiree passes away will be eligible to continue his/her $5,000 Life Insurance coverage.

Beneficiary Designation Change

You may change your beneficiary at any time during the year by completing a Beneficiary Change Form and submitting it to the DHR Insurance Division.

If You Have Questions

If you have any questions about eligibility enrollment or life insurance coverage, contact the DHR Insurance Division at **(404) 330-6036**.

Greater Georgia Life Insurance Company

Greater Georgia Life Insurance Company (Greater Georgia Life) has earned a solid reputation for its quality products, expert resources, superior services, steady growth, innovation and strong financial performance. Founded in 1982, Greater Georgia Life is a leader in the life insurance market.

IMPORTANT NOTICE:

You, as an employee, are free to designate a minor as the beneficiary of your life insurance proceeds. However, no benefits will be paid to a child who has not yet reached the age of majority (18 years old, in Georgia). Instead, you may want to designate a guardian or trustee for the benefit of the minor. If you are considering appointing a minor as your beneficiary, you may want to consult with an attorney.

RETIREE LIFE INSURANCE
09/01/2009 - 08/31/2010 *(cont'd)*

Cost of Coverage – *Has Not Changed*

You and the City of Atlanta share the cost of your life insurance coverage. The City pays for $2.97 per $1,000 of benefit and you pay $0.70 per $1,000 of benefit. The City does not contribute toward the cost of Dependent Life Insurance and Additional Life Insurance. Your cost for Life Insurance is as follows:

Amount of Insurance	You Pay	The City Pays
$5,000	$3.50	$14.85

For grandfathered retirees with Frozen Plans elected prior to May 31st, 1967 that have amounts over $5,000 the cost of coverage is listed below:

AMOUNT OF INSURANCE ($)	YOU PAY ($)	THE CITY PAYS ($)
6,000	4.20	17.82
7,000	4.90	20.79
8,000	5.60	23.76
9,000	6.30	26.73
10,000	7.00	29.70

Note: All other retirees have a flat $5,000 benefit amount.

DEPENDENTS PLAN

Amount of Insurance			Retiree Monthly Premium	
_____	Spouse:	$5,000	Spouse:	$4.00
	Children Birth – 6 months:	$600	Child:	$1.19
	Children 6 months – 19 years:	$5,000		
	Full-time students to 26 years:	$5,000		
	Surviving Spouse (if enrolled prior		**Surviving Spouse Monthly Premium**	
	to the employee passing away):	$5,000	$10.00	

THE FOLLOWING FACTS MAY ANSWER QUESTIONS YOU HAVE CONCERNING YOUR INSURANCE

PLEASE NOTE: You will be sent a Confirmation of Coverage Form if you changed coverage or provided full-time student documentation prior to 09/01/2009. It will show the coverage you chose, the dependents covered and the premium amount. You will have 14 days to make corrections to your application. Your coverage will be in effect through 08/31/2010 except for changes in family status or relocation of the carriers service area.

NO INSURANCE

If you do not want health and/or dental insurance during 09/01/2009 - 08/31/2010, you must initial **NO COVERAGE**.

COVERAGE FOR OVER-AGE DEPENDENT CHILD

To continue coverage for a dependent child between ages 19 and his/her 26th birthday, you must submit a *Full-time Student Statement* from the Registrar's Office of the accredited educational institution where your dependent child is enrolled as a full-time student or online at www.studentclearinghouse.org and attach the statement to the form in your Open Enrollment package. **The insurance carrier/HMO will terminate children over age 19, if a Full-time Student Statement is not submitted during Open Enrollment. Print your name and Social Security number on the statement.** If you wish to cover a child over 19 and under 26, who was not covered in July 1, 2008 - August 31, 2009, you must submit documentation showing a parent-child relationship (birth certificate) in addition to the full-time student statement.

COVERAGE FOR MENTAL OR PHYSICALLY DISABLED DEPENDENT

To provide coverage for a dependent who is incapable of self-support because of a mental or physical incapacity, a retiree must provide a completed *Physician Verification* of permanent disability. This form is available in the Insurance Division of DHR.

CHANGE OF ADDRESS

You should notify the Pension Division of your change of address to insure that you receive all notifications sent to retirees and to correct the City of Atlanta records.

PENSION DEDUCTIONS

As a retiree, your share of health/dental insurance will be deducted from your pension check monthly. However, in the case of late Open Enrollments, deductions may be delayed. If this occurs, back premiums and/or refunds (if applicable) will be included in your pension check as soon as possible.

ID CARDS

After your Open Enrollment Application is processed, and an eligibility file is sent to each insurance carrier, your ID card and member booklet will be mailed to your home address by the selected insurance company/HMO. The ID card should be placed in your wallet for easy access at all times. Be sure to read the member booklet carefully, and keep it in a safe place for easy reference. The member booklet will provide detailed information on how to use your insurance benefits. You will not receive a new ID card unless you make a change in your coverage.

Reimbursable claims should be filed only with your insurance carrier, not the City of Atlanta.

NOTE: All members will receive separate cards for dental and vision coverage.

Please provide a copy of your and/or your spouse's Medicare Part A and B.

As of September 1, 2009, if you need medical care prior to receiving your new ID card, use a physician and/or hospital on your new Carrier/HMO list of providers.

PLEASE RETAIN THE YELLOW COPY OF YOUR OPEN ENROLLMENT APPLICATION *OR* MAKE A COPY OF YOUR EMPLOYEE SELF SERVICE APPLICATION AND DOCUMENTATION THAT YOU HAVE SUBMITTED FOR YOUR RECORDS. ALWAYS PRINT YOUR NAME AND SOCIAL SECURITY NUMBER ON ALL DOCUMENTATION. MAKE A COPY AND ATTACH IT TO THE ENROLLMENT FORM OR STUDENT VERIFICATION FORM.

Note: HMO and POS ID cards cannot be issued without a Primary Care Physician (PCP). Kaiser Senior Advantage and Blue Cross/Blue Shield SmartValue members must complete an additional Center for Medicare and Medicaid Services (CMS) form provided by the carrier.

CHANGES IN COVERAGE

Change In Family Status

You may change your health and/or dental insurance coverage during the open enrollment period. You can also change your coverage during the year, but only if the application to change coverage is submitted **within 31 days** of your family status change because of:

- marriage;
- divorce*;
- birth, legal adoption, placement for adoption or custody change of an eligible child;
- death of a spouse or eligible child, or a dependent's leaving the household as a result of a custody agreement;
- changes in the spouse's employment which affects his/her eligibility for benefits under another employer's group benefits plan;
- a dependent who becomes ineligible as a result of reaching the plan's age limit or is no longer a full-time student; or
- Part A & B of Medicare become effective.

** Any one removed from the policy is entitled to COBRA (see Continuation of Coverage).*

** Coverage will be effective the date of the Change in Family Status. An adjustment of the premium for the level of coverage change will be deducted from your pension check.*

Call the Insurance Division at **(404) 330-6036** for a **Health Insurance Change Application Form**. Both you and your spouse (if applicable) must sign the form. Return the form to the DHR Insurance Division.

Option Changes

Option changes are permitted only during the open enrollment period. Changes made during the open enrollment period become effective on September 1, 2009.

If you move out of the service area covered by the HMO in which you are enrolled, you must request a change to another plan **within 31 days** of your move or at the next open enrollment.

If a plan listed in this brochure ceases operation, during the plan year, retirees will have a choice to move to another plan.

If you decide to move to a different plan, you must do so at Open Enrollment, unless you determine that KAISER SENIOR ADVANTAGE does not meet your needs. You may re-enroll (with 30 days prior notice) in one of the City Plans. Additionally, if you enroll in Part A and Part B of Medicare during the year, you should notify the Benefits Division. You may also change to Kaiser Senior Advantage at that time.

Surviving Beneficiaries

- A Surviving Beneficiary is eligible for coverage if they are eligible for Pension Benefits and were covered as dependents at the time of the employee's or retiree's death. A Surviving Beneficiary who terminates his/her coverage will not be eligible to return to the City Benefit Plan at any time in the future.
- A Surviving Beneficiary cannot add new dependents.
- A Surviving Beneficiary child must continue to submit Full Time Student Statements to be eligible for coverage. When the child is no longer eligible for a Pension Check, he/she will be eligible for continuation of coverage under COBRA. Contact the DHR Insurance Division at **(404) 330-6036**.

Continuation of Coverage

Information about continuing health care coverage under COBRA is in the back of the booklet.

Remember that converted coverage may not be the same as group coverage, and will be available to you at the individual rate, not at the group rate. For additional information, call the respective insurance company/HMO.

The HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), better known as the KASSEBAUM-KENNEDY LEGISLATION states:

If you cease to be an eligible dependent, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE WILL BE MAILED, by your Insurance Carrier/HMO to the last address on their file.

If you do not respond to the confirmation of coverage with changes, you will be enrolled in your current coverage and you will not be allowed to change coverage from 09/01/2009 - 08/31/2010 unless there is a change in family status or you relocate out of the service area of the carrier.

CONSUMER CHOICE OPTION

Effective January 1, 2000, Georgia law required insurers to offer a "Consumer Choice" option to members enrolling in a plan. This option allows members to receive services from a non-network provider (physician, hospital or other provider) while still being covered at an in-network level.

Although you may "nominate" any non-network provider, the nominated doctor or hospital must first agree to the following in order for your services to be covered at the in-network rate:

1. Accept the insurer's reimbursement as payment in full (in addition to the members' usual copayment, deductibles and/or coinsurance).

2. Comply with the insurer's utilization management programs.

After you select the out-of-network provider, you **must** complete a Provider Nomination Form and receive notification from the insurer that the nomination has been accepted before out-of-network providers can be reimbursed at in-network benefit levels. For any nominations to be approved, the provider must sign the form agreeing to the insurer's terms and conditions **before** that provider's services will be covered at in-network levels. The provider makes the decision regarding whether he or she will participate in the Consumer Choice Option plan.

The law does not obligate a provider to accept an insurer's terms and conditions or its reimbursement rates. If a provider elects not to sign the Consumer Choice Option Provider Nomination Form, he or she is under no obligation to do so.

If you are seeking services from a specific provider, we recommend that you check with that provider BEFORE completing the Consumer Choice Option application and making a final plan election.

The law allows insurers to increase the monthly premium rate for retirees who elect this offering. **The amount of the monthly premium increase is 17.5% over the total Kaiser HMO rates for Consumer Choice Option HMO.** Because this amount is billed to the City of Atlanta, your deductions by the City will be higher than the deductions would be if you did not choose this option. You are responsible for the applicable 17.5% increase for HMO as well as the usual retiree deduction. You should check with the DHR Insurance Division at **(404) 330-6036** to determine the exact amount to be deducted before you elect a Consumer Choice Option plan.

Selecting the Consumer Choice Option is just like selecting any other benefit option. You must do so either during annual enrollment, when newly hired or when the City's eligibility rules allow you to do so.

You must contact the DHR Insurance Division (404) 330-6036 if you wish to apply for the Consumer Choice Option on your HMO plan.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

Portability Provision

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 provides protection for employees and dependents who have pre-existing medical conditions or might be denied health coverage based on factors related to an individual's health. HIPAA includes changes that:

- Limit Exclusion for pre-existing conditions.
- Prohibit discrimination against employees and dependents based on their health status.
- Guarantee renewability and availability of health coverage to certain employers and individuals; and
- Protect many workers who lose health coverage by providing better access to individual health insurance coverage.

Under HIPAA the employer may impose a pre-existing condition exclusion with respect to an employee, dependent or beneficiary only if the following requirements are satisfied:

- A pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 6-month period prior to an individual's enrollment date;
- a pre-existing condition exclusion may not last for more than 12 months after an individual's enrollment date; and
- this 12-month period must be reduced by the length of time of the individual's prior creditable coverage, excluding coverage before any break in coverage of 90 days or more

How Portability Affects City of Atlanta Employees

Effective January 1,1998, you and your dependents did not have to satisfy a pre-existing condition waiting period if you provide certification of prior creditable coverage sufficient to satisfy the respective pre-existing condition waiting periods.

When an Employee Terminates Coverage

HIPAA requires that your Insurance Carrier/HMO provide you (and your dependents) with certificates of coverage automatically upon termination of coverage.

Special Enrollment Periods

There are special enrollment periods for you and your dependents who:

- originally declined coverage because of other coverage, and
- who exhausted COBRA benefits, lost eligibility for prior coverage, or employer contributions toward coverage were terminated, and
- an individual declining coverage must certify in writing that they are covered by another health program when they initially decline coverage under this group in order to later qualify under this special enrollment. A person declining coverage will be given notice of the consequences when they originally decline coverage.

In addition there are also special enrollment periods for new dependents resulting from marriages, births or adoptions. An unenrolled member may enroll **within 31 days** of such a special qualifying event.

Important Notes

- Individuals enrolled during special enrollment periods are not late enrollees and are subject to the normal pre-existing condition requirements unless enrolled under prior creditable coverage (excluding newborns, adoptions and pregnancies).
- Individual or dependents must request coverage **within 31 days** of qualifying event (i.e. marriages, exhaustion of COBRA, etc.).
- Evidence of prior creditable coverage is required.

Please refer to your benefit booklet for more information concerning Portability Provisions and Requirements.

AN IMPORTANT POINT TO REMEMBER

To ensure you receive timely and appropriate benefits, be certain that your current address is on file with the Pension Division and with the insurance company you select. If your address is incorrect, complete the RETIREE CHANGE OF ADDRESS NOTIFICATION FORM provided in this booklet, have it notarized and return it to the address on the form.

CHANGE OF ADDRESS FORM

CITY OF ATLANTA
Retiree Change of Address Notification

NAME (PLEASE PRINT)

SOCIAL SECURITY NUMBER

I hereby request that my MAILING ADDRESS FOR PENSION PAYMENTS be changed as follows:

OLD ADDRESS _____

_____

_____

NEW ADDRESS _____

_____

_____

PLEASE RETURN THIS FORM TO:

(Fire and Police)
ASI
2187 Northlake Parkway
Building 9, Suite 106
Tucker, GA 30084-4149

(General)
City of Atlanta
General Pension Division
68 Mitchell St. S.W., Suite 1600
Atlanta, Georgia 30335-0317

_____ | _____
RETIREE SIGNATURE | **NOTARY PUBLIC SIGNATURE**

_____ | _____
DATE | **DATE**

** The Change of Address Form must be notarized.

NOTARY STAMP

**** If you would like your PENSION CHECK to be DEPOSITED DIRECTLY INTO YOUR BANK ACCOUNT every month, please request a PENSION DIRECT DEPOSIT AUTHORIZATION form by calling the Pension Division at **(404) 330-6260**. DIRECT DEPOSIT FORMS MUST BE NOTARIZED.

CONTINUATION OF COVERAGE NOTICE

Under COBRA – the Consolidated Omnibus Reconciliation Act of 1985, Title X, terminated employees and their eligible dependents may continue group health plan coverage. We urge you to read this description of the "continuation coverage" option carefully, and to make sure you and your spouse read and understand the rights and responsibilities in connection with this continuation of coverage. Both you and your spouse must sign the front page of this enrollment application.

The American Recovery and Reinvestment Act of 2009 (ARRA), the financial stimulus law signed by President Barack Obama on February 17, 2009, includes significant changes to the COBRA continuation coverage rules. In general, the ARRA:

- Provides a 65 percent federal government subsidy of COBRA continuation coverage premiums for a maximum of nine months for certain individuals who are COBRA qualified beneficiaries because of a covered employee's involuntary termination of employment on or after September 1, 2008 and on or before December 31, 2009.
- Requires employers to pay the 65 percent portion upfront, and then allows them to deduct those costs from their Social Security and Medicare taxes **(see Claiming the New COBRA Premium Credit on Payroll Tax Forms)**.
- Retroactively allows workers who became jobless as early as September 1, 2008, and rejected COBRA coverage to reconsider and receive COBRA benefits.

The Benefits

If you are currently covered under The City of Atlanta Health Plan, you will be entitled to continue your and your family's Health Plan coverage for up to 18 months from the date coverage would have terminated because of voluntary or involuntary termination. If a qualified beneficiary is deemed disabled for Social Security, at the date of the qualifying event, or within the first 60 days following the qualifying event, the continuation coverage period is 29 months for all the members of your family who have elected COBRA. The 18-month period may be extended also if other events (such as a death or divorce) occur during that 18-month period. Employees discharged because of "gross misconduct" would not be eligible for continuation of coverage. Dependents who no longer qualify as dependents under the City of Atlanta Health Plan are eligible to apply for continuation of coverage. If you should die or become divorced, and if your spouse and dependents are covered by the City of Atlanta Health Plan at that time, they will be entitled to continue health coverage for up to 36 months. Continuation coverage is also available for your children for up to 36 months if they get married, leave your household, attain age 19, or age 26 if they are full-time students and they are not covered under another group health plan that duplicates coverage. If an Eligible Person is 60 years old on the date COBRA continuation coverage started COBRA coverage may extend up to the time of Medicare eligibility. If you have a new born child, adopt a child or have a child placed in your home pending adoption (for whom you have financial responsibility), while your COBRA continuation is in effect, you may add this child to your coverage.

The Cost

Continuation of coverage is optional on the part of the employee or dependent. Those who elect continuation of coverage will be required to pay 102% of the total monthly group premium for the applicable class of coverage. For the extended disability coverage, employees may be required to pay up to 150% of the monthly group premium for coverage during the 19th through the 29th month. Persons 60 years old on the date of COBRA eligibility may be required to pay up to 120% of the premium for extended time. There will be no contribution made by the City of Atlanta. Premiums are due monthly and in advance. You should note that your continuation coverage will stop if the premiums for this coverage are not paid on time.

If you elect to continue coverage new dependents may be added during the period of continuation on the same basis as they are added for active employees. If during continuation of coverage, health benefits and premium rates change, your coverage and costs will be affected accordingly. Should open enrollment occur during the period of your continuation you will retain your right to switch to a different option.

When Coverage Ends

If you or covered members of your family become entitled to Medicare or are covered under another employer-sponsored health plan, which does not limit coverage due to preexisting conditions, the continuation coverage from the City of Atlanta Health Plan will cease. In addition, your coverage will cease if City of Atlanta should terminate the Health Plan or you cease to pay premium. Once the period of coverage continuation has expired, anyone receiving continuation coverage will be eligible to convert to individual policies, as provided under the City of Atlanta Plan.

What You Must Do

You or your spouse or dependents must notify the DHR Insurance Division when your dependent child marries, reaches the maximum age under the Plan, ceases to be a full-time student (if between the ages of 19 and 26), or in the event you become divorced. It is important that you notify us of your or your dependents loss of Plan eligibility promptly–in advance, if possible, but no later than 60 days from the date coverage would otherwise have terminated in order to be eligible to elect continuation coverage. Within 14 days after the end of the month in which you notified the DHR Insurance Division, you or your eligible dependents will be mailed information and forms regarding continuation of coverage. You or your dependent must return the completed election forms within 60 days. If continuation of coverage is selected within 60 days you or your dependent will then have an additional 45 days to pay the applicable premium, retroactive to the date coverage would otherwise have terminated.

If you would like further information on continuation coverage under the City of Atlanta Health Plan, please contact the DHR Insurance Division at **(404) 330-6036**.

Conversion Privilege

When your group health insurance ends due to termination of employment with the City of Atlanta or due to expiration of COBRA continuation of health care coverage under the group contract you may apply for converted health coverage. For additional information contact the DHR Insurance Division at **(404) 330-6036**.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA), better known as the KASSEBAUM-KENNEDY LEGISLATION.

If you terminate your employment with the City, or your COBRA eligibility terminates, A CERTIFICATE OF GROUP HEALTH PLAN COVERAGE will be mailed by your Insurance Carrier/HMO, to the last address on their file.

If you are a new employee, have previously waived your health insurance, or are adding a dependent other than a new born (or child placed in your home pending adoption), you should provide copies of the CERTIFICATE OF GROUP HEALTH PLAN COVERAGE issued to you or your dependents, by the previous employer(s) for CREDITABLE PRIOR COVERAGE pre-existing condition exclusions, if any.

IMPORTANT NOTICE FROM THE CITY OF ATLANTA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Atlanta and new prescription drug coverage first available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

1. **Starting January 1, 2006, new Medicare prescription drug coverages were made available to everyone with Medicare.**
2. **The City of Atlanta has determined that the prescription drug coverage offered by BlueChoice and Kaiser are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay for the period September 1, 2009 - August 31, 2010.**
3. **Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.**

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. The City of Atlanta has determined that your prescription drug coverage with the City of Atlanta is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay for the period September 1, 2009 - August 31, 2010.

Starting January 1, 2006, prescription drug coverage was available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provided at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Anyone with Medicare can enroll in a Medicare prescription drug plan from November 15 through December 31, each year with no penalty. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later.

IF YOU DO DECIDE TO ENROLL IN A MEDICARE PRESCRIPTION DRUG PLAN AND DROP YOUR CITY OF ATLANTA PRESCRIPTION DRUG COVERAGE, BE AWARE THAT YOU MAY NOT BE ABLE TO GET THIS COVERAGE BACK.

If you drop your coverage with the City of Atlanta and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back later. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering a Medicare prescription drug program in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you may still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. Thus the importance of really looking at a plan before you give up coverage through The City of Atlanta.

You should also know that if you drop or lose your coverage with the City of Atlanta and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that creditable coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay an extra penalty if you later decide to enroll in Medicare coverage.

IMPORTANT NOTICE FROM THE CITY OF ATLANTA ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE *(cont'd)*

For more information about this notice or your current prescription drug coverage…

Contact our office for further information or call the DHR Insurance Division at **(404) 330-6036**.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage can be found in the following places:

- visit www.medicare.gov for personalized help;
- call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number); or
- call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15. 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

PLEASE NOTE: If you sign up for any **Medicare Advantage Plan** (other than Senior Advantage offered by Kaiser or SmartValue offered by Blue/Cross Blue Shield) that may be offered to you directly by various vendors, **YOUR COVERAGE THROUGH THE CITY OF ATLANTA WILL BE TERMINATED**. If you have any questions about this, please call the DHR – Insurance Division at **(404) 330-6036** before signing up for another plan.

GLOSSARY

Application: A signed statement of facts requested by the company on the basis of which the company decides whether or not to issue a policy. This then becomes part of the health insurance contract when the policy is issued.

Approved Amount: The amount determined by the Medicare carrier to be reasonable and fair for each service.

Beneficiary: The person designated or provided for by the terms to receive the proceeds upon the death of the insured.

Benefit Package: A collection of specific services or benefits that the HMO and Indemnity is obligated to provide under terms of its contracts with subscriber groups or individuals.

Benefit Period: The period of time during which benefits are available, such as a year or for the lifetime of the contract.

Benefits: The amount payable by an insurance company for covered services.

Carrier: The insurance company responsible for processing claims; it may perform the carrier function on its own behalf, or for another entity who pays losses; under the Medicare program, for example, the Social Security Administration selects private insurance companies to administer Part B claims.

Claim: A demand to the insurer for the payment of benefits under the insurance contract.

Coinsurance: The fixed percentage of covered charges you must pay after any deductible has been subtracted. For example, if a plan pays 80 percent of covered charges (after applying any deductible), you would be responsible for the deductible and the 20 percent balance.

Consumer Choice Option (CCO): A health plan mandated in 1999 by the Georgia General Assembly. This plan allows members to nominate a non-network provider that will act as a part of the network. An employee who has selected the CCO may elect a qualified provider to render any covered services. Member is subject to normal rules and conditions that apply to a contracted network provider, i.e., reimbursement, usual customary and reasonable costs, and prescription drugs. Members will incur additional costs if they choose the CCO health plan.

Contingent Beneficiary: Person named to receive proceeds or benefits should an unforeseen event prevent the named Primary Beneficiary(ies) from collecting benefits(or insurance).

Conversion Privilege: A privilege granted in an insurance policy to convert to a different plan of insurance without providing evidence of insurability. The privilege granted by a group policy is to convert to an individual policy upon termination of group coverage.

Coordination of Benefits: Establishes procedures to be followed in the event of duplicate coverage thus assuring that no more than 100 percent of the costs of care are reimbursed to the patient.

Copayment: A fixed dollar amount you must pay for a service or benefit provided by a plan.

Coverage: The amount or extent to which any particular treatment or service is insured by a health provider.

Deductible: The amount of covered charges you must pay before the plan pays benefits, for example, calendar-year deductible and inpatient hospital deductible. Generally, no more than two or three family members must meet the calendar-year deductible. However, some plans have a family calendar-year deductible, which can be met by any or all of those covered.

Dental Care: Coverage may include routine diagnostic and preventive services and one or more of the following treatment services: restorative, crown and bridge, endodontic, oral surgery, periodontal, prosthetic, and orthodontic. Some prepaid plans (DMOs) limit coverage to preventive services for children.

Disability: A limitation of physical or mental functional capacity resulting from sickness or injury. It may be partial or total. (See also Partial Disability and Total Disability.)

Domestic Partnership: A union in which two individuals (unrelated by blood) of the opposite or same sex choose to share their lives in a close and committed relationship of mutual caring; who live together and have signed a ***Declaration of Domestic Partnership*** in which they have agreed to be jointly responsible for basic living expenses incurred during the Domestic Partnership.

Effective Date: The date on which the insurance under a policy begins.

Eligibility Period: A specified length of time, frequently 30 days following the eligibility date during which an individual member of a particular group will remain eligible to apply for insurance under a group life or health insurance policy without evidence or insurability.

Eligible Date: The date on which an individual member of a specified group becomes eligible to apply for insurance under the (group life or health) insurance plan.

Eligible Employees: Those members of a group who have met the eligibility requirements under a group life or health insurance plan.

Evidence of Insurability: Any statement of proof of a person's physical condition and/or other factual information affecting his/her acceptance for insurance.

Exclusions: Charges, services, or supplies that are not covered. A plan does not provide or pay for excluded items, nor do charges for them apply toward deductibles and catastrophic limits.

Flexible Spending Account (FSA): A benefit option that reimburses employees for certain expenses they incur. Money is deducted from pay checks on a pre-tax basis. It most often covers reimbursements for medical expenses not covered under other insurance, or child care expenses.

Grace Period: A specified period – thirty-one days – after a premium payment is due, in which the policyholder may make such payment, and during which the protection of the policy continues.

HCFA: Health Care Financing Administration. The agency of the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

HIPAA: Health Insurance Portability and Accountability Act of 1996. A federal law which requires employers to provide certificates of coverage to minimize pre-existing condition exclusions.

Health Insurance: Protection that provides payment of benefits for covered sickness or injury. Included under this heading are various types of insurance such as accident insurance, disability income insurance, medical expense insurance, and accidental death and dismemberment insurance.

Health Maintenance Organization (HMO): An organization that provides a wide range of health-care services for a specified group at a fixed periodic payment. The HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, and hospital-medical plans.

Hospice Care: A coordinated program at home and/or on an inpatient basis, offering easing of the patient's pain and discomfort, and providing supportive care, for a terminally ill patient and the patient's family, provided by a medically supervised specialized team under the direction of a licensed or certified hospice-care facility or agency.

GLOSSARY *(cont'd)*

In-Network Provider: Selected physicians who furnish a comprehensive array of healthcare services. Under contractual agreement, doctors accept the insurance carriers "Usual, Customary and Reasonable" amounts, as payment-in-full.

Inpatient Services: The care provided while a bed patient is in a covered facility. Provides extra benefits for services not covered at all by the base plan, and that in some cases pays balances of services not covered completely by the base plan; most are characterized by large benefit maximums, ranging from $250,000 to no limit; above an initial deductible, major medical reimburse the major percentage of all charges for hospital, doctor, private nurses, and so on; the policyholder insurer pays the remaining co-insurance.

Managed Care: Health-care systems that integrate the financing and delivery of appropriate health-care services to covered individuals by arrangements with selected providers to furnish a comprehensive set of health-care services, explicit standards for selection of health-care providers, formal programs for ongoing quality assurance and utilization review and significant financial incentives for members to use providers and procedures associated with the plan.

Medicaid: State programs of public assistance to people, regardless of their age, whose income and resources are insufficient to pay for health care. Title 19 of the federal Social Security Act provides matching federal funds for financing state Medicaid programs, effective January 1, 1966.

Medicare Supplements (Medigap): Policies sold by insurance companies that help supplement the amounts not paid by the Medicare program for covered services.

Medicare: The government health insurance system for people over the age of 65 (and for certain other groups), created by the 1965 amendments to the Social Security Act. This includes new coverage for prescription drugs under Medicare Part D.

Miscellaneous Expenses (Ancillary Charges): Hospital charges (other than room and board) such as for x-rays, drugs, and laboratory fees.

Open Enrollment Period: The period of time stipulated in a group contract in which eligible of the group can choose a health plan alternative for the coming benefit year.

Out-of-Area Benefits: The scope of emergency benefits (and related limitations) available to HMO members while temporarily outside their defined service areas. Some HMOs offer unlimited out-of-area emergency coverage. Others impose a stated maximum annual dollar benefit. Emergency coverage is usually the only HMO benefit in the total benefit package for which members may need to file claim forms for reimbursement of their out-of-pocket expenditures for care.

Out-of-Network Providers: Physicians who do not participate in a contractual relationship, that provide services and care for a predetermined amount to a carrier's member.

Outpatient Services: The care provided to you in the outpatient department of a hospital, in a clinic or other medical facility, or in a doctor's office.

Partial Disability: The result of an illness or injury that prevents an insured from performing one or more of the functions of his or her regular job.

Participating Physician: A doctor or supplier who agrees to accept Medicare assignment on all claims under the medicare program. Agreement by which, under the contractual agreement, the doctors accept the insurance carriers usual, customary, and reasonable amount as payment in full.

Point-of-Service (POS): This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the network for an additional cost.

Preadmission Certification: A procedure whereby (1) you or your doctor is required to contact your plan before your admission to a hospital, and (2) your plan determines the appropriateness of the admission and the length of stay by using established medical criteria.

Preexisting Condition: A physical and/or mental condition of an insured that first manifested itself prior to the issuance of his or her policy or that existed prior to issuance and for which treatment was received.

Preferred Provider Organization (PPO): A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Premium: The fee you must pay (monthly, biweekly, quarterly) on a regular basis for your enrollment in a plan.

Prescription Drugs: Outpatient drugs and medicines which, by United States law, cannot be obtained without a doctor's prescription.

Primary Care Network: The structure for these networks will vary considerably depending on the specific network. It may range from a loose association of physicians in a geographic area with a limited sharing of overhead, patient referral, call, etc. to a more structured association with commonly owned satellite clinics, etc.

Primary Care Physician (PCP): Provide treatment of routine injuries and illness and focuses on preventative care. Serves as gatekeeper for managed care. The American Academy of Family Practice defines primary care as "care from doctors trained to handle health concerns not limited by problem origin, organ systems, gender or diagnosis.

Prior Authorization: Procedure used in managed care to control utilization of services by prospective reviewing and approval.

Providers: Those institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, pharmacists, etc.). Providers in a defined service area are principally owned by, affiliated with, employed by, or under contract to an HMO.

Service Area: The geographic area where prepaid plan (HMO) providers and facilities are available to you. This area would be the same as, or within, the plan's enrollment area.

Total Disability: An illness or injury that prevents an insured person from continuously performing every duty pertaining to his or her occupation or engaging in any other type of work. (This wording varies among insurance companies.)

UCR (Usual, Customary, and Reasonable): A maximum payment allowed for a given medical service based on a statistical formula calculated by an insurance company to determine the amount it will pay on a given medical service.

Waiting Period: The length of time an insured must wait from his or her date of enrollment or application for coverage to the date his or her insurance is effective.

NOTES

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